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ABSTRACT

This report focuses on nursing educational and practice issues that government officials may have to address in the near future. The report provides statistical information on nurses, compares statistics for white and black nurses, and recommends policies for the future. Data was gathered for the report during a three-year study of 5,175 registered nurses and 3,942 student nurses. The report is divided into six chapters. Chapter 1 looks at the supply of nurses and discusses the registered nurses' labor force participation and work patterns. Chapter 2 addresses the nurse maldistribution problem. It investigates nurses' working patterns in the inner city, rural areas, and in services to the elderly. Chapter 3 discusses the importance of government intervention for the racial and economic integration of the nursing corps. Chapter 4 concentrates on the "1985 Plan" for requiring baccalaureate degrees for all professional nurses. Chapter 5 discusses the nurses' collective action movement and their level of support for unionization and strikes; and the relationships among personal and educational background, work experience, career aspirations and orientation, and this support. Chapter 6 investigates who speaks for the working nurse. It examines the membership rates in professional associations and who participates in them. (KC)

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PUBLIC POLICY AND PLANNING FOR NURSE EDUCATION AND PRACTICE

A Report For Governmental Officials

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INTRODUCTION TO THE SERIES OF REPORTS

The professional staff of the Program of Health Services Delivery, Bureau of Governmental Research, University of Maryland (College Park) has prepared a series of four reports about student and registered nurses for persons interested in and involved with the delivery of health services. Each report presents research findings from a nationwide study and offers recommendations by which a different set of persons in the health sector can effectuate positive change. The reports are directed to nurse educators, leaders of professional nursing associations, administrators of health facilities, and local, state, and federal elected and administrative officials who are involved in health delivery plans and decisions.

The data utilized in preparing these reports were collected during 1977 and 1978. The data base is unique in that it is extremely large and geographically representative. Information was obtained from interview responses of administrators at 42 associate, diploma, and baccalaureate schools of nursing and from survey responses of 589 faculty members and 3,942 student nurses at the schools. In addition, information was obtained from survey responses of 5,172 randomly selected graduate nurses registered to practice in Alabama, California, Louisiana, Michigan, Missouri, and New York.

The data base is also unique in that it contains information about a large sample of black student and registered nurses. Stratified sampling techniques resulted in 28.7 percent of the student and 18.3 percent of the registered nurse samples being composed of black respondents. In contrast, the random sampling technique would have produced an 8 percent black student and a 3 percent black registered nurse sample.

In addition, the data base is unique in that it permits longitudinal analysis of the nurses' career and work patterns. The survey instruments included questions which asked about each job the nurses had held since graduating from their generic nursing educational program. Questions also were included which asked about the nurses' educational and personal backgrounds and career goals, orientations, and satisfactions. The complete study design and sample descriptions are presented in the appendix of each report.

The data collection effort was part of a three year study entitled "The Nursing Profession and Black Nurses." The study was funded by the Division of Nursing (Bureau of Health Manpower, Health Resources Administration, U.S. Department of Health and Human Services -- Project No. R01NU00570). This research effort was initiated to answer two questions: (1) Why are there so few black nurses? and (2) Is the health delivery system adversely affected by the sparsity of black nurses? The answers to these questions are highlighted in this section and are discussed more fully in the various reports.

The answer to the first question, "Why are there so few black nurses?" is multifaceted. No single answer can be offered, but an understanding can be gleaned from the following reasons:

- o Until the 1960's, few schools of nursing admitted black students and those schools which did had highly restrictive admission policies.
- o When nursing leaders became interested in integration, they had to compete with other academic disciplines which were seeking to sexually and racially integrate their student bodies.
- o Nursing is competing with other disciplines in attempting to recruit black high school students with high academic credentials.
- o Prospective students are not receiving adequate counseling to learn about careers in nursing or various nursing educational programs.

- o Recruitment efforts are not directed toward the typical black student nurse who is a nontraditional student. That is, she is a 31 year old, married mother from a lower socio-economic status background, attending an associate degree nursing program after having worked for several years as a nurses' aide or practical nurse.
- o Schools of nursing are not responsive to the needs of nontraditional students. Most have not made provisions for: part-time, evening, and summer programs; tutorial assistance; flexible and extensive course offerings; and financial aid at a level sufficient to relieve the necessity for employment.
- o It is difficult to interest blacks in enrolling in schools in which there are few, if any, black teachers or black students.
- o Black student and registered nurses perceive high levels of racial discrimination in interpersonal relations and advancement opportunities within the nurses' work environment.
- o Black nurses had to wait longer and had to obtain higher educational credentials before being promoted than did their white colleagues.

The study findings clearly and unequivocally answered the second question in the affirmative: YES, THE HEALTH DELIVERY SYSTEM IS BEING ADVERSELY AFFECTED BY THE SPARSITY OF BLACK NURSES because:

- o Black nurses spend a greater proportion of their eligible registered nurse years working than do white nurses.
- o Black nurses work on a full-time basis significantly more than do white nurses.
- o Black nurses interrupt their careers less frequently than do their white colleagues.
- o Black nurses' work patterns are less disrupted by familial demands than are those of white nurses.
- o Black nurses change employers less frequently than do white nurses.

- o Black nurses are less geographically mobile than are white nurses.
- o Black nurses spend a substantial proportion of their careers working in inner city areas, a much higher proportion than that of white nurses.
- o Black nurses spend a substantial proportion of their careers delivering health care to poor patients, a much higher proportion than that of white nurses.
- o Black nurses spend a substantial proportion of their careers delivering health care to minority patients, a much higher proportion than that of white nurses.

It is hoped that nurse educators, nursing leaders, administrators of health facilities and governmental officials after reading the reports will become convinced that integration of the nursing corps is important to the stability of the nurse employment sector and is an important way to provide increased access to health care for the disadvantaged. It is also hoped that the recommendations offered in the four reports will lead to policy and program changes that will improve the nurses educational and work experiences.

The reports in the series and their focuses are:

- o Public Policy and Planning for Nurse Education and Practice: A Report for Governmental Officials, focuses on selected policy issues and planning decisions affecting nurses during the coming decade.
- o Nurses and the Educational Process: A Report to Nurse Educators, focuses on the recruitment, admission, and retention of black and white student nurses in the three generic educational programs and the programmatic influences on career plans and work practices.
- o Registered Nurses at Work: A Report to Administrators of Health Facilities, focuses on the nurses' career patterns, goals, orientations, and satisfactions.

- o Nursing Professional Associations and Their Constituencies: A Report to Nursing Leaders, focuses on the nurses' perceptions of and relationship with their associations and the ramifications of associational norms, practices, and policies.

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PUBLIC POLICY AND PLANNING FOR NURSE EDUCATION AND PRACTICE:
A REPORT FOR GOVERNMENTAL OFFICIALS

INTRODUCTION

This report focuses on nursing educational and practice issues that we expect governmental officials to address in the near future. As the federal role in nursing education diminishes, state and local officials will be faced with such issues as nurses' work patterns, nurse maldistribution, integration of the nursing corps, and requirements for professional practice. The issues selected for discussion in this book will not only affect the working nurse, but also will affect the delivery of health services.

Some may claim that this book is written in an advocacy style. They would be correct. We have discussed these issues in our other books in this series and believe they are of major concern. For public officials to derive solutions to problems that will be acceptable to the nursing corps, a variety of viewpoints must be considered. We have tried to present the viewpoints of the 1,175 registered nurses and, to some extent, the 3,942 student nurses who have participated in this three year study. We are pleased to play the role of advocate for registered and student nurses, as these men and women are truly devoted to the provision of health care and are the most knowledgeable about the workings of the health delivery system.

It is also correct to say that we are somewhat prescriptive in style. We have used the term "should" and have offered suggestions about the resolution of nurse policy questions. While we do not feel that our suggestions are panaceas, we do believe that they deserve consideration. A brief overview of the book may serve to highlight our major findings and suggestions.

Chapter 1 looks at the supply of nurses to deliver health services to American citizens. It discusses the registered

nurses' labor force participation and work patterns. It examines the nurses' complete work history from the time they graduated from their generic nursing program until 1977. It looks at continuity of work, positional turnover, full-time/part-time employment status, career mobility, and the affects of family responsibilities on the nurses' careers. The findings indicate that nurses are reliable and predictable labor force participants, for the respondents in our study:

- o remained employed as registered nurses for the majority of their career lives,
- o did not interrupt their careers frequently,
- o held full-time positions,
- o did not display rapid positional turnover,
- o changed jobs to improve career status,
- o predictably interrupted their careers and sought part-time employment when raising children.

We also found that black nurses were more stable and continuous labor force participants than were their white colleagues. In addition, we found that:

- o Nurses do not have many opportunities for upward mobility.
- o Nurses do not have incentives to return to full-time employment once family demands have decreased.

Our findings in this chapter demonstrate that public officials can serve as catalysts for changes in educational and labor policies. They can encourage:

- o colleges and universities to offer part-time and evening programs to inactive nurses so that they can keep abreast with their profession to facilitate reentry into the labor force,
- o employers of nurses to offer flexible work schedules so that nurses can work while meeting family demands,

- o employers to offer proportional fringe benefit packages to part-time employees to dissuade nurses from leaving the work force,
- o employers to count part-time employment toward seniority status, so that nurses will have reason to return to work full-time once family demands have decreased.

Chapter 2 addresses the nurse maldistribution problem. It investigates whether nurses work in shortage areas with underserved clientele groups. Specific attention focuses on working patterns in inner city and rural areas and services to elderly, poor and minority clients. The findings demonstrate that nurse maldistribution is, indeed, a serious problem:

- o 81 percent of the respondents never worked in a rural area,
- o 76 percent of the respondents never worked in an inner city area,
- o 72 percent of the respondents never worked with a predominantly elderly clientele,
- o 79 percent of the respondents never worked with a predominantly black clientele,
- o 64 percent of the respondents never worked with a predominantly poor clientele.

Three mechanisms are suggested for correcting maldistribution problems:

- o selective recruitment of students by schools of nursing,
- o providing for educational experiences in areas in need of increased numbers of nurses,
- o providing for continuing education opportunities for registered nurses desiring baccalaureate and graduate degrees.

Chapter 3 discusses the importance of governmental intervention for the racial and economic integration of the nursing

corps. It looks at governmental mandates and financial support for efforts to increase the heterogeneity of the nurse labor force. The findings demonstrate that integration did not occur until federal prescriptions and funds provided incentives to increase the numbers of minority and disadvantaged student nurses. Relationships were found between the funds provided by the federal government via the Nurse Training Act and:

- o the increase in the number of black student nurses,
- o the increase in the number of associate degree programs which attracted students from low socio-economic status backgrounds, who were older and parents, and who had experience as sub-professional health workers,
- o loans, grants, and scholarships to aspiring students from disadvantaged backgrounds and to registered nurses seeking collegiate degrees,
- o recruitment and retention programs by schools of nursing to graduate increased numbers of black nurses.

These findings left little doubt that state and local officials, in light of the diminishing federal role, need to:

- o increase attention to nursing educational programs,
- o increase the level of financial support to schools of nursing,
- o increase the level of financial support to student and registered nurses to help them defray nursing educational costs.

Chapter 4 concentrates on the "1985 Plan" which mandates that a baccalaureate degree is required for entry into the professional practice of nursing. It discusses the attitudes of nurses toward the baccalaureate degree requirement and outlines the ramifications of the plan for students, registered nurses, schools, and health facilities. It looks at who will be affected by the new requirement and whether schools of nursing

have prepared for two levels of nursing practice. The findings show that:

- o There is little support among student and registered nurses for the baccalaureate degree requirement.
- o Most seriously affected will be student and registered nurses from low socio-economic status backgrounds, blacks, older men and women, and persons with family responsibilities.
- o Schools are not prepared to offer transferrable credits to or meet the demand of the large numbers of registered nurses who want to continue their education to attain the baccalaureate degree in nursing.

Several states have begun to take steps to ease the way for implementation of the Plan. These efforts need to be expanded and encouraged throughout the nation. These steps include:

- o legal prescriptions that all accredited schools of nursing offer credits that are transferrable to baccalaureate degree programs,
- o increased classroom space for registered nurses returning to school,
- o creation of examinations whereby registered nurses can be tested and earn credits for competency of their nursing skills,
- o courses offered at neighborhood or health facility sites where nurses can earn baccalaureate degree credits,
- o proper counseling for aspiring nurses to ensure that students are aware of the benefits and disadvantages of the three types of nursing educational programs.

Chapter 5 discusses the nurses' collective action movement. The registered nurses' level of support for unionization and strikes are investigated and the relationships with personal and

educational background, work experiences, and career aspirations, orientations, and satisfactions are tested. Comparisons are made between the levels of job satisfaction of those nurses who are represented by bargaining agents and those who are not. The findings demonstrate that:

- o Over one-third of the nurses are represented by a bargaining agent in their work place.
- o The majority of nurses believed that it is right for nurses to strike.
- o The nurses most supportive of collective action were male, black, young, and from working class backgrounds.
- o Support for collective action was related to desires for advancement, expanded roles, material rewards, and upgraded status.
- o Job dissatisfaction was highly associated with support for collective action.
- o Representation in the work place did not result in higher levels of job satisfaction.
- o Representation did result in attaining higher wages and higher levels of satisfaction with material rewards.

The findings clearly indicate that the nurses' collective action movement will continue to grow and gain proponents. As more nurses organize, it can be expected that the number of their strikes will increase. To prevent work stoppages by nurses, public officials can prevail on employers of nurses to:

- o listen and be responsive to their nurse employees' complaints,
- o improve the nurses' work conditions,
- o devise ways to increase the nurses' opportunities for advancement,
- o assist nurses in their efforts to redefine their roles in the delivery of health services,

- o provide channels and increase opportunities for nurses to participate in decisions which affect their work, their clients, and the manner by which they deliver health care.

Chapter 6 investigates who speaks for the working nurse when public officials hear testimony on issues. It asks, "Do the leaders of nursing professional associations speak for the working nurse?" It examines the membership rates in professional associations and sees who and how many participate in organizational activities and decisions. And it looks at how many nurses take it upon themselves to contact public officials to express concern about nursing issues. The findings show that:

- o Nursing professional associations represent only a fraction of the registered nurse corps.
- o Associational membership is not reflective of the compositional characteristics of the nursing corps.
- o Nursing leaders and associational participants ... have earned higher educational degrees and hold higher status nursing positions than that of the average working nurse.
- o The majority of the working nurses do not write, call, or visit local, state, and federal officials to express their viewpoint on nursing issues.

These findings indicate that public officials must solicit viewpoints from all nursing sectors when considering the implications of nursing issues. We suggest that public officials:

- o widely advertise public hearings in the media and at those sites in which nurses work, such as, hospitals, schools, and neighborhood centers,
- o hold public meetings in places that are accessible to the nurses who are responsible for the day to day care of the states' constituency.

Efforts to solicit opinions of working nurses will prove advantageous to deriving public policies which are acceptable

and ones that will address the problems within the health sector. Remember, these nurses best of all understand the problems of the health delivery system from a day to day practical perspective, for they are the persons responsible for the immediate delivery of health services to our family, friends, neighbors, and constituents.

CHAPTER 1

THE NURSE LABOR FORCE

Persons responsible for health planning, charged with ensuring that residents of all communities have adequate access to health care, are concerned with the number and work practices of health practitioners. Much of their attention always has focused on the question, "Are there enough nurses?", for nurses comprise approximately 60 percent of the health labor force. During the next few years, it can be expected that state and local governmental officials will be forced to pay increased attention to the numbers and the distribution of nursing personnel.

A major reason that health sector demands will increasingly target the state and local political arenas is that the federal government has shown signs that it intends to decrease its involvement with nursing education. Since 1964, with the passage of the Nurse Training Act, the federal government has been generous in providing financial support for nursing education. It has made grants to schools of nursing for starting and expanding programs, enlarging enrollments, offering innovative programs, enhancing the educational opportunities of disadvantaged persons, and instituting graduate level programs, as well as specialty curricula for nurse practitioners and nurse anesthetists. For the past several years, this involvement has cost the federal government over \$100 million annually.

Federal financial support has been given to schools of nursing without the sanction of the President during each of the past several years. President Carter, in the belief that the nation has an adequate number of nurses, has eliminated funds for nursing education from his budget requests to Congress. The only exception has been a modest request for nurse practitioner

programs. Congress has not honored the President's requests and has reinstated the funds to schools of nursing. However, most congressional watchers agree that, in the effort to balance the federal budget during these times of scarce resources, the present situation of congressional funding will not continue. Thus, the responsibility for nursing education will return to the states and localities.

State and local officials will learn (if they are not already aware) that there is a lively debate as to whether or not there is an adequate number of nurses. Nursing professional leaders will show myriads of newspaper advertisements for nurses to fill hundreds of vacant positions. Health facility administrators will provide information about their difficulties in recruiting and retaining nurses as employees. Their arguments will indicate that there is an inadequate number of nurses to staff health facilities and to provide health services to the residents of the communities within the states.

However, the argument about the numbers of nurses needed by the health system quickly becomes muddled with myths about the problems of women workers. As can be read in the Congressional Record's publications of the Nurse Training Act hearings, administrators contend that nurses constitute an unpredictable and unreliable labor pool. Male employers decry that women are not devoted to their careers and that nurses have high turnover and attrition rates. Many contend that if only unemployed registered nurses would return to work, then nurse shortages would no longer be a problem.

There are many arguments made to counter the "women not dedicated" arguments, but only one will be reiterated here. Nurses claim that there is no reason for them not to interrupt their careers. Nursing jobs are depicted as "dead end"; that is, there is little opportunity to achieve upward mobility and, similarly, there is little chance that interruptions will cause

downward mobility. Therefore, there are no career loss considerations to be taken into account that serve to inhibit or dissuade nurses from leaving the employment sector.

While this chapter will not provide definitive answers to all the questions raised, it will present to public officials data by which they can better understand the nurses' work habits. It will examine the registered nurses' complete employment history from the time they graduated from their generic nursing educational program until 1977 to ascertain whether there is stability in the nurses' labor force participation. Specifically, continuity of work, positional turnover, full-time/part-time employment status, and the effects of familial responsibilities on the nurses' work patterns will be investigated. In addition, the work histories of black and white nurses will be compared. And career mobility will be examined to see whether upward or downward trends are characteristics of the nurses' work lives.

The findings of this chapter will show that nurses constitute both a reliable and predictable labor force, but for the most part, have not enjoyed upward career mobility opportunities. The data should indicate to health administrators that employers not only can plan for the number of nurses who will be needed to deliver health services, they can predict the number of nurses available to fill vacant positions. Moreover, recommendations will be offered to demonstrate that changes can be made to enhance the attractiveness of nursing careers by expanding opportunities for career advancement.

ARE NURSES RELIABLE LABOR FORCE PARTICIPANTS?

The findings indicate that nurses are reliable labor force participants. An examination of Table 1.1 reveals that nurses rarely leave their profession and most remain employed for the

TABLE 1.1
LABOR FORCE PARTICIPATION
(Percent reported unless specified)

	<u>Total</u>	<u>White</u>	<u>Black</u>
Percent of total R.N. years worked			
0 - 25	7.1	8.1	3.7
26 - 50	13.0	13.7	6.9
51 - 75	23.5	25.2	16.3
Over 75	56.4	52.0	73.1
Mean percentage	72.59	70.49	80.41
Number of career interruptions			
0	42.2	38.0	58.6
One	28.6	29.6	24.6
Two	16.9	18.5	10.2
Three	8.2	9.3	4.3
Four or more	4.1	4.6	2.4
Mean number of interruptions	1.08	1.16	.69
Mean number of years not in labor force per interruption	4.35	5.46	2.08
Percent of years worked full time			
0	4.5	5.3	1.7
1 - 50	35.7	39.1	16.2
51 - 75	21.2	21.2	20.1
Over 75	38.5	32.5	61.9
Mean	56.47	52.04	73.13
Percent of years worked part time			
0	56.6	51.9	73.4
1 - 50	36.4	40.0	23.3
51 - 75	4.9	5.5	2.9
76 - 100	2.1	2.6	.4
Mean	11.66	13.20	6.00
Number of employers			
1 - 2	35.9	32.8	47.85
3 - 4	31.6	32.8	26.3
5 - 6	17.9	18.9	14.1
Over 6	14.6	15.5	12.1
Mean	3.90	4.05	3.47
Mean number of years per employer	4.22	4.05	4.87
Reasons for terminating positions			
Personal	42.8	44.3	34.0
Husband	28.6	33.5	9.6
Family responsibilities	32.4	36.1	19.1
Self improvement	46.5	45.9	49.4
Job dissatisfaction	19.3	19.9	17.3
Position terminated	18.1	17.9	18.9
Changed field of nursing	26.2	29.3	23.5

majority of their career lives. Less than .5 percent report never having worked as a registered nurse. Moreover, only 7.1 percent have spent three-quarters of their years since graduation unemployed. Instead, the findings show that the vast majority of nurses have spent at least half of their career lives holding paid nursing positions. Indeed, the average nurse has been employed 73 percent of her eligible R.N. years.

Black nurses are more continuous labor force participants than are their white colleagues. Three quarters of the blacks reported working more than 75 percent of the years since graduating from their generic program. The average black nurse has worked 80.4 percent of her eligible R.N. years.

As can be seen from the Table, the nurses' labor force participation was not erratic. They did not interrupt their careers frequently. Over 40 percent of the respondents had never stopped working for six months or longer. Another 29 percent had only one career interruption. In fact, the average nurse had only stopped working one time since graduating from her basic nursing program. Black nurses displayed a less interrupted working pattern than did whites.

When the nurses left the labor force, however, they remained unemployed for several years. White nurses averaged 5.5 years of unemployment, while blacks averaged only two years.

Another dimension of workforce stability was discovered when examining the respondents' full-time and part-time work status. As can be seen in the Table, the majority of nurses have been employed on a full-time basis. Nearly 60 percent of the nurses have spent more than half of their working years in full-time employment. Black nurses spent a significantly greater proportion of their working years in full-time work than did whites (mean percentages of full-time work were 73.13 and 52.04, respectively).

Over half of the respondents had never been employed on a part-time basis. Nearly three quarters of the blacks, as compared to 51.9 percent of the whites, claimed to have never held

a part-time position. In addition, blacks spent a smaller percentage (mean=6.0%) of their careers employed part-time than did whites (mean=13.2%).

POSITIONAL TURNOVER

The respondents in this study did not display rapid positional turnover. On the average, the nurses worked for less than five employers over the course of their careers. In fact, one-fifth of the nurses were still working at the same health facility as they did when first employed. Moreover, the nurses had long tenure in each position. They spent an average of over four years with each employing facility.

Black nurses remained with the same health facility longer (mean number of years per employer was 4.87) than did their white colleagues (mean=4.05). Moreover, they changed jobs less frequently than did whites (mean=3.47 jobs versus 4.05).

When examining the reasons that nurses gave for terminating positions, it is seen that the major causes, with few exceptions, were career oriented. The reasons most frequently given concerned career improvement. Nearly half of the white and black nurses had left positions to continue their education, to move to posts which offered more responsibility, or to secure promotions. Personal reasons, such as retirement or sickness, were the second most frequently mentioned.

Family reasons, such as responsibility of children, were the third most important of the reasons for terminating employment. Black nurses were far less likely to give this as a reason (19.1 percent) than were their white colleagues (36.1 percent). Disruptions caused by a husband, such as his being transferred to another city to work, was the fourth category of reasons. Again, blacks were less likely to attribute a spouse related reason (9.6 percent) than were whites (33.5 percent).

Fifth among reasons was that the nurses changed jobs to enter a different field of nursing. Approximately one-quarter of the whites and blacks explained that this was their reason for having left a post. Surprisingly, less than 20 percent of the nurses terminated employment for job dissatisfaction reasons. Some left their jobs because they felt that the work was too demanding or they were dissatisfied with lower or higher level personnel. Others disapproved of administrative policies or felt that there was too much paper work or red tape.

PREDICTABILITY OF THE NURSES' LABOR FORCE PARTICIPATION

The nurses' labor force participation is predictable, according to our findings. The nurses' work patterns are affected by the demands of child rearing. However, in recent decades these affects have diminished, as nurses have been continuing to work while raising their children.

To ascertain the affects of parenthood on labor force participation, the nurses' careers during six life stages were examined. The stages corresponded to the respondents' marital status and children's ages. The stages are: 1) single, without children; 2) married, without children; 3) with children under 6 years of age; 4) with children ages 6 to 11 years; 5) with children ages 12 to 17; and 6) with adult children, 18 years of age or older.

As can be seen in Table 1.2, both the continuity and extent of the nurses' labor force participation has been affected by having children. Nurse parents interrupt their careers more frequently and spend lower proportions of their time working forty hours a week than do those without child rearing responsibilities.

It can also be seen that those nurses with young children at home display less continuous work patterns than do those with older children. Mothers with preschoolers are least likely to work full-time and are most likely to interrupt their careers.

TABLE 1.2
WORK PATTERNS AND LIFE STAGES
(Means Reported)

	<u>Single Childless</u>	<u>Married Childless</u>	<u>Children Under 6</u>	<u>6-11</u>	<u>12-17</u>	<u>Adult Children</u>
Mean Percentage years worked during six life stages						
Total	84.2	70.8	52.9	66.7	75.8	73.7
White	84.8	70.0	49.5	64.0	74.5	72.3
Black	81.1	73.2	69.0	78.1	82.2	80.0
Mean Number of Interruptions						
Total	.20	.35	.88	.44	.34	.48
White	.20	.36	.95	.49	.37	.53
Black	.18	.32	.58	.24	.18	.27
Mean Number of Years Interrupted						
Total	.47	.69	3.81	1.42	.98	1.76
White	.47	.68	4.31	1.64	1.10	1.97
Black	.41	.71	1.48	.56	.46	.93
Mean Percent of Full Time Work						
Total	58.79	61.24	33.49	45.0	55.49	56.76
White	57.84	59.40	27.25	38.69	50.87	52.74
Black	62.14	69.50	62.12	71.23	76.17	75.05
Mean Percent of Part Time Work						
Total	2.87	5.79	16.07	20.29	18.53	15.41
White	3.02	6.40	18.0	23.20	21.0	16.92
Black	2.22	2.59	7.37	8.21	7.35	7.81

In contrast, the majority of nurses with children beyond elementary school age return to the labor force as full-time participants.

When examining racial differences, it can be seen that having young children in the home has a significantly less pronounced inhibitive affect on black nurses' labor force participation than it does for whites. There are not great differences in the black and white nurses' working patterns while childless. Yet when preschoolers are in the home, whites expend less than half of their time working, as compared to the blacks who spend nearly 70 percent of those years in the labor force. After children begin school, the white nurses have a more continuous work pattern, but they do not approximate the proportion of time worked by their black colleagues.

It has been noted that black nurses interrupt their careers far less frequently and for shorter periods of time than do their white colleagues. Career interruptions for both races are related to the presence of children in the home and the level of responsibility associated with the age of children. Still less than half of the blacks stop working during the preschool age stage, as compared to almost 70 percent of the whites. Moreover, whereas three-quarters of the black nurses work continuously while their children are in school, less than 60 percent of the whites refrain from interrupting their careers during those stages.

For both racial groupings, the largest number of years spent away from nursing work is while they are raising preschool age children. Once the children enter school, the nurse parents reenter the work force. While white nurses spend less than two years at home once their children reach 6 years of age, blacks spend less than one year unemployed once their children begin elementary school.

Similarly, the white nurses' full or part-time status is closely dictated by familial demands. Thus, while they spend nearly 60 percent of their childless years working full-time,

less than 30 percent of their years with pre-schoolers is spent holding a full-time job. This percentage increases to 38.69 while the children are in elementary school. Once the children reach junior high school age, the white nurses return to full-time employment at least half of their remaining working years.

In contrast, there is very little fluctuation among blacks as to the percent of years spent in full-time positions during the various life stages. While the percent drops somewhat during early child rearing years, black nurses still remain working full-time over 60 percent of the time.

Few nurses work part-time when they are not responsible for raising children. Once children arrive, whites spend approximately one fifth of their years working on a part-time basis. In contrast, blacks spend less than 9 percent of their working years holding part-time posts.

RECENT CHANGES

This discontinuous working pattern created by demands of childrearing has changed, especially during the past two decades. When plotting the nurses' work patterns during various time frames, it can be seen (Table 1.3) that the percentage of nurses who work outside the home while raising children has risen each decade since the 1930's. In contrast to the 1930's, when half of the mothers worked, three-quarters held paid positions in the 1950's. During the 1970's, close to 90 percent of the nurse parents were employed.

The most dramatic changes are seen in the percentage of mothers holding full-time positions. The percentage of nurses who have worked full-time at some point while raising preschoolers has nearly tripled since the 1930's, while there has been a six fold increase in parents with school age children working a forty hour week. Over the span of years, however, nurse parents appear to have preferred part-time employment. The percentage

TABLE 1.3

WORK PATTERNS OF NURSES WITH CHILDREN DURING DECADES 1930-1978
(Percentages reported)

<u>Family Responsibility</u>	<u>1930-1939</u>	<u>1940-1949</u>	<u>1950-1959</u>	<u>1960-1969</u>	<u>1970-1978</u>
<u>Married</u>					
Not work	19.1	13.8	13.1	10.0	7.9
Full time	9.3	4.2	9.0	14.4	15.4
Part time	62.4	66.3	56.3	49.4	52.6
Full and Part time	9.3	15.7	21.7	26.1	24.2
<u>Preschool age children</u>					
Not work	48.8	33.5	24.1	21.7	12.4
Full time	9.3	8.0	12.8	19.9	21.7
Part time	36.0	49.0	43.6	34.9	41.2
Full and Part time	5.8	9.6	19.5	23.5	24.7
<u>Children 6 yrs. or older</u>					
Not work	58.8	39.3	26.3	16.2	11.0
Full time	5.9	12.0	12.8	18.7	20.3
Part time	35.3	39.3	48.9	47.2	50.3
Full and Part time	0.0	9.4	12.0	17.9	18.5

of parents who hold part-time positions has not risen dramatically over four decades.

CAREER ADVANCEMENT

At the time of the survey, the largest percentage of nurses (44.8%) held staff positions (see Table 1.4). Over 12 percent held positions which were essentially outside a promotional hierarchy, such as private duty (2.5%), office and industrial posts (6.4%), and positions within private or public schools (3.6%). Two percent had earned a certificate for some type of specialty practice, such as anesthesia or a nurse practitioner (without a master's degree). While over 5 percent of the respondents were teachers, 3.8 percent had barred themselves from upward mobility by accepting teaching posts before earning a master's degree. Over one-quarter (28.2%) had ascended the promotional ladder to supervisory posts; 11.4 percent held head nurse positions, 11.5 percent were nurse supervisors, and 5.3 percent had attained high level administrative posts.

The Table also presents the percentage of years the nurses have held various level positions during the course of their careers. As can be seen in the Table, 91 percent of the nurses, at one time in their career, held the position of staff nurse. Over 35 percent of the respondents had spend over half of their careers working as staff nurses; the percentage for blacks (43.3%) is even higher. Indeed, 9.7 percent of the nurses never held any position other than a staff post since graduating from their generic nursing program; 15.5 percent of the blacks had spent all their eligible R.N. years as staff nurses. The average white nurse spent 39.61 percent of her nurse years working as a staff nurse as compared to the 47.59 average for blacks.

Compared to staff positions, the nurses spent very little time in supervisory posts. While 35 percent of the nurses had been head nurses, only 5.9 percent spent the majority of their career lives in that level position. Over 85 percent of the

TABLE 1.4
POSITIONS HELD BY THE NURSES
(Percentages Reported Unless Specified)

POSITION	<u>TOTAL</u>	<u>WHITE</u>	<u>BLACK</u>
STAFF NURSE			
Present Position	44.8	45.0	44.3
Percent of Total R.N. Years Worked			
Zero	9.0	9.5	7.6
1 - 25	33.4	34.4	29.9
26 - 50	21.2	21.9	19.2
51 - 75	15.0	14.0	14.2
Over 75 percent	22.4	19.3	29.1
Mean Percentage of R.N. Years	41.46	39.61	47.59
HEAD NURSE			
Present Position	11.4	10.8	13.7
Percent who have held position	34.9	34.3	36.7
Mean Percentage of R.N. Years	9.41	8.71	12.15
SUPERVISOR			
Present Position	11.5	10.7	14.7
Percent who have held position	22.9	22.6	25.6
Mean Percentage of R.N. years	6.81	6.51	8.66
HIGH LEVEL ADMINISTRATOR			
Present Position	5.3	5.6	4.3
Percent who have held position	8.2	9.1	7.4
Mean Percentage of R.N. Years	2.31	2.45	2.11
PRIVATE DUTY NURSE			
Present Position	2.5	2.6	2.1
Percent who have held position	12.5	13.2	10.0
Mean Percentage of R.N. Years	2.39	2.34	2.65
OFFICE AND INDUSTRIAL NURSE			
Present Position	6.4	7.6	1.6
Percent who have held position	17.8	21.3	5.2
Mean Percentage of R.N. Years	4.01	4.72	1.33

TABLE 1.4 CONTINUED

	<u>TOTAL</u>	<u>WHITE</u>	<u>BLACK</u>
SCHOOL NURSE			
Present Position	3.6	3.7	3.1
Percent who have held position	6.9	7.1	6.1
Mean Percentage of R.N. Years	1.72	1.66	2.00
CERTIFICATE SPECIALTY			
Present Position	2.3	2.2	3.0
Percent who have held position	3.1	3.2	3.3
Mean Percentage of R.N. Years	1.00	.99	1.18
TEACHER WITHOUT MASTERS' DEGREE			
Present Position	3.8	4.0	4.3
Percent who have held position	11.6	11.9	10.4
Mean Percentage of R.N. Years	2.52	2.59	2.32
GRADUATE DEGREE EDUCATOR, CLINICAL SPECIALIST			
Percent Position	3.5	3.4	4.0
Percent who have held position	4.9	4.8	5.5
Mean Percentage of R.N. years	1.35	1.32	1.54

nurses had never held a supervisory post, and 80 percent of those who had been supervisors spent less than half their careers at that level. Those who had been promoted to high level administrative posts were relative novices to such responsibility ($\bar{x}$ =2.31% of R.N. years).

When looking at the highest position ever held by the respondents (see Table 1.5), it can be seen that 43.5 percent of the nurses never rose above a staff nurse position. At one point during their careers, 18.3 percent of the nurses had been head nurses, 14.9 percent had been supervisors, and 7.1 percent had held a high level administrative post. For 2 percent the highest position held was that of a certificate specialists and for another 6.3 percent teaching without a master's degree was the positional apex of their career.

TABLE 1.5
HIGHEST POSITION HELD BY NURSES
(Percentages reported)

<u>Position</u>	<u>Total</u>	<u>White</u>	<u>Black</u>
Staff nurse	43.5	44.0	41.2
Head nurse	18.3	18.5	18.2
Supervisor	14.9	13.9	18.1
High level administrator	7.1	8.2	6.3
Certificate, Specialist	2.0	2.0	2.0
Teacher without master's degree	6.3	7.2	6.1
Graduate degree level position	3.4	3.1	4.2

CAREER MOBILITY

To ascertain whether or not the nurses are upwardly mobile, their entire careers were examined to see what level positions they had held and whether they had moved to higher or lower level posts when changing jobs. The upward mobility trend was then categorized into four major groupings (although 13 patterns were coded). For those who had worked less than a year, a code was developed which will not be presented here for it was too soon to discern any mobility patterns. The second grouping was labelled downward mobility and was composed of those coded as displaying: 1) a clear downward trend, 2) a discontinuous working pattern which goes downward, and 3) changes from posts with an advancement track to posts which offer no opportunities for advancement (e.g., private duty). It should be noted that those nurses who were upwardly mobile but accepted dead end posts as they became older were not included in this category. Rather, the latter positions were ignored in the categorization.

The third group of nurses are those who have not experienced any career mobility. This group is composed of nurses who have remained in the same status position throughout their careers, regardless of whether stagnation was marked by discontinuous or continuous working patterns. The fourth group is composed of those nurses who were somewhat upwardly mobile; that is, over a career of 15 years or longer, they only rose from staff to head nurse. The fourth grouping represents those nurses who were upwardly mobile.

As can be seen in Table 1.6, the largest percentage of nurses (49.7%) fall within the no mobility category. While many like to claim that discontinuity of work decreases upward mobility opportunities, the findings show that 36.9 percent of the nurses who have worked continuously have not been promoted. Only 19.5 percent of the nurses, however, have experienced downward mobility. One-tenth of the respondents have been somewhat upwardly mobile, and one-fifth have experienced upward mobility.

TABLE 1.6
NURSES' MOBILITY PATTERNS
(Percentages reported)

<u>Mobility Pattern</u>	<u>Total</u>	<u>White</u>	<u>Black</u>
Too soon to discern	2.9	3.4	.8
Downward mobility	19.5	20.3	16.8
Total no mobility	49.7	50.9	47.1
No mobility with discontinuous work pattern	12.8	13.6	11.8
No mobility with continuous work pattern	36.9	37.3	35.3
Somewhat upwardly mobile	7.9	8.5	5.9
Upwardly mobile	20.0	16.9	29.4

CORRELATES TO CAREER MOBILITY

As can be seen in Table 1.7, upward mobility is related to the nurses' present family situation. Divorced and widowed nurses were much more likely to be upwardly mobile than were those who were single or married. Similarly, those who provided the primary support or were jointly involved with their husbands in supporting their families were the most likely to have attained advancement.

When examining the nurses' life stage, it is seen that raising children is a deterrent to upward mobility. Those nurses who were single or married without children were the most likely to have advanced in their careers. In contrast, those with elementary school age children were the least likely to be upwardly mobile. Nurses with adult children were most likely to display downwardly mobile career patterns. In addition, it can be seen that as the number of children in the home increases,

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TABLE 1.7

MOBILITY PATTERN BY SELECTED PERSONAL,
EDUCATIONAL AND WORK BACKGROUND CHARACTERISTICS
(Percentages reported)

	<u>Downward Mobility</u>	<u>No Mobility</u>	<u>Somewhat Upwardly Mobile</u>	<u>Upward Mobility</u>
Marital Status				
Single	15.5	46.2	19.6	18.7
Divorced/widowed	16.2	44.6	16.6	22.6
Married	17.8	47.3	15.4	19.5
Family Support				
Father	10.8	48.2	19.4	21.6
Spouse	18.0	47.6	15.4	19.0
Spouse and respondent	16.4	42.3	17.8	23.5
Respondent	13.9	47.2	13.9	25.0
Life Stage				
Single, childless	11.9	42.6	16.2	29.3
Married, childless	12.8	46.1	17.8	23.3
Preschool children	14.2	61.6	7.6	16.7
Children 6-11 years	18.7	51.8	14.8	14.6
Children 12-17 years	19.6	46.9	17.9	15.7
Adult children	22.7	39.1	19.6	18.5
Age Married				
16-21 years	17.2	47.6	15.0	20.2
22-24 years	17.1	45.3	16.6	21.1
25-28 years	18.7	47.1	15.5	18.8
29 older	19.2	49.1	13.1	18.7
Age When Had First Child				
16-21 years	12.7	45.5	18.2	23.7
22-24 years	20.7	47.6	14.3	17.4
25-28 years	16.7	46.7	16.6	22.9
29 older	19.1	47.5	16.0	17.4
Number of Children				
1-2	15.8	47.2	15.6	21.4
3-4	19.9	44.8	16.8	18.5
5 or more	22.0	44.0	15.0	19.0
Education				
Associate	16.9	49.2	15.1	18.7
Diploma	18.1	46.9	15.2	19.8
Generic Baccalaureate	14.0	48.7	15.6	21.8
Continuing education B.S.	18.1	47.3	16.5	18.1
Graduate degree	16.9	37.9	22.9	22.3
Work				
Percent total R.N. years worked				
0-66	18.0	47.0	16.0	19.1
67-88	17.7	46.1	16.8	19.4
89-100	15.7	47.0	16.4	20.8
Percent total R.N. years worked part time				
1-11	17.5	47.2	13.3	22.2
12-33	18.7	43.5	17.6	20.1
34-100	20.7	48.5	13.6	17.2

so does the likelihood of downward mobility. The highest percentage of upwardly mobile nurse mothers had only one or two children.

It is interesting to note that delayed marriage and childbearing is not related to upward mobility. Indeed those nurses who married while young, ages 16 to 24 years, were more likely to have advanced within their careers than were those who had married when 25 years of age or older. Similarly, those nurses who were very young, under 21 years of age, when bearing their first child, were significantly more likely to be upwardly mobile than were those who were older mothers. While this finding contradicts the literature which claims that deferred childbearing is related to career advancement, it makes sense that those who became mothers while attending or before entering their generic nursing educational program, indeed, would be dedicated to their chosen profession. If childbearing did not deter these women from finishing their education, it is unlikely that childrearing would deter them from working as nurses.

EDUCATIONAL BACKGROUND

When looking at educational attainment and career mobility, it can be seen that those nurses who have earned a baccalaureate or graduate degree were the most likely to have advanced within the profession. In contrast, nurses with associate degrees were the least likely to be upwardly mobile. A similar proportion of diploma degree nurses have attained upward mobility, as have careers marked by downward trends.

It is interesting to note that the nurses' generic educational degree appears to dictate their chances for advancement. In contrast to the 18.7 percent of nurses with a generic associate degree and 19.8 percent with a diploma who have obtained advancement, 21.8 percent of those with generic baccalaureate degrees have upwardly mobile career patterns. Associate degree graduates were not especially downwardly mobile. However, almost

half of these R.N.'s have remained in the same status position as they held when graduating from their generic nursing educational program.

WORK EXPERIENCE

As suggested above, continuity of work is related to upward mobility. As can be seen, those who have worked the largest percentage of their R.N. years have attained upward mobility. In contrast, those who worked the lowest percentage of time have career patterns marked by downward mobility. Similarly, full-time employment is related to career advancement. Those nurses who have spent the largest percentages of their working years in part-time employment were the most likely to display downwardly mobile career trends, while those who have spent the majority of their working years in full-time employment were the most likely to have advanced within the profession.

SITUATIONAL CHANGES

Many have asserted that various changes, such as geographic and employer moves and interruptions have inhibiting affects on upward mobility. In contrast, continuing education is said to foster career advancement. To test whether or not these assertions are valid, the positions held by the nurses before and after each of the above changes were made and (where applicable) were compared to see whether there were discernible, positional status effects. The findings are presented in Table 1.8.

As can be seen in the Table, the change most frequently made by the nurses was a change in employers, while the least likely change was for continuing education. For the largest percentage of nurses, these changes had no affect on their status. Yet, it can be seen that over one-quarter

TABLE 1.8
EFFECTS OF CHANGES ON CAREER MOBILITY
(Percentages reported)

<u>Effects</u>	<u>Geographic Change</u>	<u>Employer Change</u>	<u>Continuing Education</u>	<u>Inter- ruptions</u>
Have not experienced change	35.1	15.1	52.1	45.8
Have not returned to work	.5	0	.5	8.8
Changed to part-time work	6.5	8.5	.6	13.6
Lost status	10.4	14.7	1.0	8.2
No status change	31.6	35.5	30.4	14.8
Increased status	15.9	26.2	15.4	8.8

of the nurses had been able to increase their positional status by changing employers. Over 15 percent had also advanced by continuing education and by geographic mobility. Career interruptions had not resulted in decreased status to the extent expected. Indeed, larger percentages of nurses had lost status from changing geographic settings and employers than had from interrupting their careers. These findings further substantiate that nurses' careers are most frequently marked by stagnation, that is very little has an inhibiting or boosting affect on career mobility.

SUMMARY

This chapter tested the assertions that nurses, because female, constitute an unreliable and/or unpredictable labor force in that they work part-time, interrupt work frequently, and display rapid positional turnover rates. By examining the

nurses' work patterns from the time they graduated from their generic nursing educational program until 1977, it was found that the assertions were untrue. The respondents in our study rarely left the nursing profession and most remained employed for the majority of their career lives.

In addition, the nurses' labor force participation was not erratic. They did not interrupt their careers frequently. Moreover, the majority of nurses held full-time positions. The nurses also did not display rapid positional turnover. When they left positions, they usually did so in order to improve their career status.

The nurses did not constitute an unpredictable labor force. When they interrupted their careers for six months or longer, they did so to raise preschool age children. In addition, part-time employment was related to family demands. However, an examination of the nurses' work patterns during each decade since the 1930's clearly demonstrates that more nurse parents are working, and more are working full-time in the 1970's than during any of the previous four decades.

Black nurses were more likely than their white colleagues to display continuous and full-time working patterns. Their work histories indicated that their careers were not seriously disturbed by parental responsibilities and few left the work force for extended periods of time for child rearing or other reasons. Moreover, when blacks did interrupt their careers, they did so for shorter periods of time than did their white colleagues.

The chapter also examined the nurses' opportunities for career advancement. It was seen that almost half of the nurses held staff positions at the time of the survey, and that only one-quarter had ascended the promotional ladder to supervisory posts. When looking at career mobility patterns, it was found that nearly half of the nurses have experienced no mobility. Mobility was seen to be related to familial responsibility.

Single nurses and those with no children were the most likely to be upwardly mobile, while those with young children were least likely to have advanced.

The strongest correlates of upward mobility were advanced education and full-time employment. Those nurses who had earned a baccalaureate or a graduate degree and who had spent their nurse years working full-time were those most likely to advance. However, for the most part, regardless of continuity or interrupted work, the largest proportion of nurses had not advanced in their careers from the level of position they held upon graduation from their generic nursing educational program.

These findings have implications for educational and labor policies. Public officials can act as catalysts for policies and programs that would better utilize female nurses and provide them with opportunities for upward mobility. Colleges and universities should be asked to encourage nurse mothers, especially those with young children, to keep abreast with and obtain status in their profession by continuing their education and earning college and graduate degrees. Part-time and evening educational programs can be initiated that would permit R.N.'s to combine the roles of mother and students. This would enable nurses to educationally prepare to return to work during the years when family demands are high.

Employers, knowing that young children create problems for working nurse mothers, should be encouraged to initiate flexible time schedules so that nurses would find it easier to work on a full-time basis. Part-time employment can count toward seniority status, so that when family demands decrease, nurses will have reason to want to increase the number of hours they work each week. Moreover, part-time employment can offer a proportion of fringe benefits that accrue to full-time workers and become an incentive for remaining in the work force.

These changes should be welcomed by a profession composed primarily of female workers. To ignore the advancement aspirations of the overwhelming majority of nurses, because they are

women or because they are mothers, not only relegates the profession to second class status within the employment sector, but also dissuades nurses from being committed labor force participants.

CHAPTER 2

NURSE DISTRIBUTION AND MALDISTRIBUTION

In recent years, health planners have shifted their attention from the numbers of health personnel to their distribution. State and local officials, while hearing conflicting reports about the shortage of nurses, will find there is a consensus that nurse maldistribution is a serious problem. More nurses are needed to work with the elderly and to staff nursing home and extended care facilities in order to meet the health care requirements of their state's increasing numbers of aged citizens. Community health centers and facilities in rural and inner city areas are understaffed, thus decreasing the availability of health care to poor and minority residents. The lists of vacancies for faculty positions within schools of nursing is increasing, as few nurses hold graduate degrees and are prepared for teaching roles.

During our study, we examined the work patterns of registered nurses to ascertain whether they were working in underserved locations and with underserved populations. Our findings indicated that nurses were not working in those facilities, fields, and locations in which they are most needed. Nor were they serving patients who are most disadvantaged by the present health delivery system.

In addition, we examined the personal, educational, and work experience backgrounds of those nurses who did work in underserved areas with elderly, minority, and poor patients. We found that these nurses did have identifiable characteristics and that an argument could be made for the selective recruitment of nursing students. We also found that increasing certain educational experiences and enhancing advanced educational opportunities to student and registered nurses were

important ways to reduce nurse maldistribution. This chapter will discuss these findings for your attention.

WHERE DO NURSES WORK?

FACILITIES

A review of Table 2.1 reveals that few nurses work or have worked in facilities which cater to the elderly. Only 12 percent of the nurses have had experience working in nursing homes. Moreover, for most that experience did not constitute a major portion of their careers. The mean percentage of career time spent employed by nursing homes was 1.72 for blacks and 2.37 for whites.

At the time of the survey, only 5 percent of the nurses were employed in nursing homes or in extended care facilities. Their tenure with their present employing agency, while lowest when compared to those working in other types of facilities, averaged 4.35 years (see Table 2.5).

Over 20 percent of the nurses had worked at one time in community or public health centers. A greater proportion of black nurses (28.3%) had experience in these types of facilities than did whites (19.1%). In addition, blacks spent a greater proportion of their working years ($\bar{x}=10.43\%$) employed in public health than did their white colleagues ($\bar{x}=4.62\%$). In 1977, 10 percent of the nurses were employed in community health settings and the average public health nurse had worked in her present facility for seven years.

As noted in the Appendix, which fully explains the methodology of this study, few of the respondents had earned graduate degrees (8.2%). More blacks had attained a master's degree education (10.6%) than had whites (7.6%). Therefore it is not surprising that only 10 percent of the nurses had ever been employed by schools of nursing or by a college or university. As might also be expected, only a small percentage of the nurses'

career lives ($\bar{x}=2.76\%$) had been spent working in an institution of higher education. There was little difference in the experience levels between racial groupings.

At the time of the study, only 5 percent of the nurses were employed by institutions of higher education. The average faculty member had spent 5.3 years working at the same school (see Table 2.5). However, nurse educators changed employers more frequently than did nurses working in any other type of health facility. For example, whereas 45.3 percent of hospital nurses had only worked for one or two employers over the course of their careers, 56.5 percent of the faculty nurses had worked in five or more employment settings.

Almost all the nurses have had some work experience in hospital settings since graduating from their generic nursing program. Indeed, most had worked over half of their career lifetime in hospitals. Black nurses spent a somewhat larger percentage ($\bar{x}=63.41\%$) of their U.N. years in hospital work than did their white colleagues ($\bar{x}=52.75\%$). At the time of the survey, 65.4 percent of the nurses were employed in hospitals, and they averaged 6.04 years with their present agency.

Doctors' offices and health maintenance organizations (HMO's) have been the employment setting for 15 percent of the nurses. Very few black nurses (2.3%), however, had ever held a position in this setting. Over the course of their careers, nurses, regardless of their racial heritage, had spent a small percentage of their time ($\bar{x}=3.21\%$) working in doctors' offices or in HMO's. Yet, the 5 percent of nurses who were working in doctors' offices at the time of the study had been in their present post for an average of 9.23 years.

Fifteen percent of the nurses had been employed at one time in industrial, government, or primary and secondary school facilities. The actual percentage of their career years spent working in these facilities was small ($\bar{x}=3.87\%$). However, those nurses (8.0%) who were employed in industrial type settings at

TABLE 2.1

NURSES' EXPERIENCE IN VARIOUS TYPES OF HEALTH FACILITIES
(Percentages reported unless specified)

	<u>Total</u>	<u>White</u>	<u>Black</u>
NURSING HOME OR EXTENDED CARE FACILITY			
Presently Employed	5.0	5.7	2.4
Percent of total R.N. Years			
0	88.2	87.7	89.9
1 - 25	8.9	9.3	7.8
26 - 50	2.0	2.0	1.9
51 - 75	.5	.6	.1
Over 75	.4	.4	.3
Mean Percentage of R.N. Years	2.26	2.37	1.72
COMMUNITY OR PUBLIC HEALTH			
Presently Employed	5.1	4.4	7.9
Percent of total R.N. Years			
0	79.1	80.9	71.7
1 - 25	12.8	12.6	13.5
26 - 50	4.4	3.8	5.7
51 - 75	2.4	1.7	4.8
Over 75	1.6	1.0	3.6
Mean Percentage of R.N. Years	5.76	4.62	10.43
INSTITUTION OF HIGHER EDUCATION			
Presently Employed	5.0	4.9	5.3
Percent of total R.N. Years			
0	90.3	90.1	91.2
1 - 25	5.2	5.3	4.9
26 - 50	2.8	2.9	2.1
51 - 75	1.3	1.3	1.3
Over 75	.4	.4	.5
Mean Percentage of R.N. Years	2.76	2.80	2.64
HOSPITALS			
Presently Employed	61.7	61.3	63.4
Percent of total R.N. Years			
0	4.3	4.2	5.1
1 - 25	22.4	24.3	16.6
26 - 50	18.1	19.3	12.6
51 - 75	19.6	20.0	16.8
Over 75	35.6	32.2	48.9
Mean Percentage of R.N. Years	55.06	52.75	63.41

TABLE 2.1 CONTINUED

	<u>Total</u>	<u>White</u>	<u>Black</u>
DOCTOR'S OFFICES, HMO			
Presently Employed	4.7	5.8	.3
Percent of total R.N. Years			
0	84.9	81.3	97.7
1 - 25	10.6	13.9	1.9
26 - 50	2.7	3.4	.1
51 - 75	1.2	1.4	.2
Over 75	.6	.8	.1
Mean Percentage of R.N. Years	3.21	3.97	.44
INDUSTRY, GOVERNMENT, SCHOOLS			
Presently Employed	8.0	8.2	7.6
Percent of total R.N. Years			
0	84.2	83.3	86.6
1 - 25	9.7	10.6	7.4
26 - 50	3.8	4.0	2.7
51 - 75	1.8	1.7	2.5
Over 75	.5	.4	3.3
Mean Percentage of R.N. Years	3.87	3.87	3.99

the time of the survey had the longest tenure ($\bar{x}=9.07$ years) of any group of respondents.

FIELDS OF NURSING

When examining the fields in which nurses have worked (see Table 2.2) it can be seen that the majority have had experience in medical and surgical nursing. Indeed the average nurse has spent over 25 percent of her career working in these two fields.

While many elderly patients are seen by medical nurses, few of the respondents (9.9%) stated that they have had experience in geriatrics. Moreover, the nurses have averaged less than 2 percent of their work experience in that field.

Community and public health specialties are also rare among nurses. Approximately 3 percent of the respondents claim these as their fields, although over 20 percent have worked in public health centers.

Nurses also lack experience in such specialty areas as intensive and coronary care. These fields, which require familiarity with sophisticated technology, have attracted only 15 percent of the sample. The nurses spent an average of 6.3 percent of their careers in such fields. Emergency care does not fare much better. Approximately 8 percent of the sample have worked in emergency or in operating rooms.

Less than 10 percent of the sample have had experience in education. In addition, fewer than 3 percent have spent time in nursing research. These low figures no doubt reflect and/or are caused by the shortage of nurses with graduate degrees.

In contrast to the few nurses with experience in the above personnel shortage fields, almost 25 percent of the respondents have worked in obstetrics and gynecology. Pediatrics has attracted 15 percent of the nurses. In this age of birth decline, it should be noted that these fields are becoming, if they are not already, labor surplus areas.

TABLE 2.2
NURSES' EXPERIENCE IN VARIOUS FIELDS OF NURSING
(Percentages reported unless specified)

	<u>Total</u>	<u>White</u>	<u>Black</u>
GERIATRICS			
Percent of total R.N. Years			
0	91.1	90.5	93.5
1 - 25	5.1	6.8	4.1
26 - 50	1.8	1.6	1.6
51 - 75	.5	.6	.3
Over 75	.5	.5	.4
Mean Percentage of R.N. Years	1.99	2.08	1.45
MEDICAL AND SURGICAL			
Percent of total R.N. Years			
0	28.8	28.4	31.1
1 - 25	31.4	33.4	23.3
26 - 50	16.5	16.8	15.3
51 - 75	10.4	10.2	10.3
Over 75	12.9	11.2	20.0
Mean Percentage of R.N. Years	27.99	26.49	33.65
COMMUNITY AND PUBLIC HEALTH			
Percent of total R.N. Years			
0	96.8	97.5	94.6
1 - 25	2.1	1.7	3.2
26 - 50	.5	.4	.8
51 - 75	.4	.3	1.0
Over 75	.2	.1	.4
Mean Percentage of R.N. Years	.83	.61	1.60
INTENSIVE OR CORONARY CARE			
Percent of total R.N. Years			
0	84.5	83.3	90.2
1 - 25	6.4	7.0	3.5
26 - 50	3.9	4.2	2.6
51 - 75	2.3	2.5	1.5
Over 75	2.9	3.0	2.3
Mean Percentage of R.N. Years	6.31	6.65	4.55
EMERGENCY OR OPERATING ROOMS			
Percent of total R.N. Years			
0	92.1	91.8	93.6
1 - 25	4.7	5.0	3.4
26 - 50	1.6	1.7	1.1
51 - 75	.9	.9	.7
Over 75	.7	.6	1.2
Mean Percentage of R.N. Years	2.19	2.18	2.35

TABLE 2.2 CONTINUED

	<u>Total</u>	<u>White</u>	<u>Black</u>
EDUCATION			
Percentage of total R.N. Years			
0	91.6	91.4	92.0
1 - 25	4.7	4.9	4.1
26 - 50	2.2	2.3	2.1
51 - 75	1.1	1.1	1.3
Over 75	.4	.3	.5
Mean Percentage of R.N. Years	2.32	2.32	2.39
OBSTETRICS			
Percentage of total R.N. Years			
0	76.8	76.6	78.1
1 - 25	14.2	14.6	12.7
26 - 50	3.9	4.2	2.9
51 - 75	2.1	2.3	1.5
Over 75	2.8	2.3	4.8
Mean Percentage of R.N. Years	6.67	6.44	7.74
PEDIATRICS			
Percentage of total R.N. Years			
0	85.2	84.9	86.0
1 - 25	9.6	10.2	7.6
26 - 50	2.1	2.0	2.3
51 - 75	1.3	1.3	1.5
Over 75	1.8	1.6	2.6
Mean Percentage of R.N. Years	4.16	3.97	4.98
OUTSIDE OF NURSING			
Percentage of total R.N. Years			
0	95.2	95.1	96.1
1 - 25	3.5	3.7	1.5
26 - 50	.9	.8	1.0
51 - 75	.3	.3	.9
Over 75	.1	.1	.5
Mean Percentage of R.N. Years	.89	.90	.84

Although these findings indicate that nurses are not experienced in those fields in which there is a need, it should be applauded that nurses work as nurses. As can be seen in Table 2.2, few respondents have left nursing for other work experiences. Less than 5 percent of the sample have worked outside nursing since graduating from their generic educational program.

GEOGRAPHIC SETTINGS

Very few nurses (19.3%) have had experience working in rural areas (see Table 2.3). White nurses were significantly more likely to have worked in sparsely populated areas (22%) than were their black colleagues (7.7%). In addition, only a small proportion of the nurses' career lives ($\bar{x}=5.78\%$) was spent working in rural locales.

At the time of the survey, only 10.6 percent of the white and 1.8 percent of the black nurses were employed by health facilities within rural areas. Of those working in these sparsely populated areas, a sizeable percentage were employed by ambulatory care facilities (see Table 2.5). Indeed, 14.3 percent of the nurses working in industry, government, and public and private schools worked in rural areas. Over 10 percent of the nurses who were employed by doctors and public health agencies worked in rural settings. In addition, 17.3 percent of those working in nursing homes were doing so in sparsely populated locales. In contrast, only 6.9 percent of the hospital nurses were employed by rural health facilities.

The nurses' work histories also reveal that 76.3 percent had never worked in health facilities within the inner city. Black nurses, however, were significantly more inclined to work within the inner city (41.4%) than were their white colleagues (18.4%). In addition, 30.8 percent of the black nurses had spent more than half of their R.N. working years in these locales. In contrast, only 8.1 percent of the whites had spent

TABLE 2.3

NURSES' EXPERIENCE IN DIFFERENT TYPES OF GEOGRAPHIC SETTINGS
(Percentages reported unless specified)

	<u>Total</u>	<u>White</u>	<u>Black</u>
RURAL AREAS			
Presently Employed	8.7	10.6	1.8
Percent of total R.N. Years			
0	80.7	78.0	92.3
1 - 25	11.6	13.1	5.8
26 - 50	3.5	3.6	1.2
51 - 75	2.6	2.9	.1
Over 75	2.1	2.4	.4
Mean Percentage of R.N. Years	5.78	6.54	.04
INNER CITY			
Presently Employed	13.8	9.4	30.5
Percent of total R.N. Years			
0	76.3	81.6	58.6
1 - 25	9.1	7.2	6.9
26 - 50	4.2	3.1	3.7
51 - 75	4.1	4.8	9.7
Over 75	6.1	3.3	21.1
Mean Percentage of R.N. Years	11.01	8.83	29.21
CITY			
Presently Employed	54.7	54.4	55.7
Percent of total R.N. Years			
0	20.2	18.9	25.7
1 - 25	22.0	24.0	13.8
26 - 50	15.1	16.3	10.6
51 - 75	15.8	16.9	11.5
Over 75	16.6	40.8	38.4
Mean Percentage of R.N. Years	44.19	41.71	48.57
SUBURBIA			
Presently Employed	17.4	19.3	10.2
Percent of total R.N. Years			
0	69.8	68.4	76.9
1 - 25	15.6	16.1	12.9
26 - 50	6.9	7.2	5.1
51 - 75	3.8	4.5	1.8
Over 75	3.8	3.8	3.3
Mean Percentage of R.N. Years	10.76	10.81	7.31

the majority of their careers working in the inner city. Overall, the mean percent of eligible R.N. years spent in the inner city was 29.21 for blacks and 8.83 for whites.

In 1977, only 13.8 percent of the nurses were employed by inner city health facilities. The percentage of blacks working in this locale (30.5%) was much higher than that of whites (9.4%). Over 15 percent of nurse educators were working in schools located in the inner city and 14 percent of hospital and industrial nurses were employed in this type of setting. Of those employed in community and public health facilities, one-fifth worked in the inner city. Few of those working in doctor's offices or nursing homes, however, worked within the inner city area.

Although not in the inner city, 80 percent of the respondents had worked at one point within urban settings. Indeed, the nurses had spent more than an average of 40 percent of their career lives employed in facilities within an urban setting. A sizeable proportion of the nurses (31.2%) had experience within suburban health facilities. More whites had worked in the suburbs (31.6%) than had blacks (23.1%), and the whites had spent a larger proportion of their work lives ($\bar{x}=10.81\%$) in suburban facilities than had their black colleagues ($\bar{x}=7.31\%$).

At the time of the study, 54.7 percent of the respondents were working in health facilities located in urban and 17.4 percent in suburban locations. Indeed with the exception of those employed by nursing homes and industry, over 50 percent of those employed in each type of health facility were spending their working hours in the city. Over one-quarter of the nursing home and industrial nurses were employed in suburban health facilities.

CLIENTELE GROUPS: AGE OF PATIENTS

For the most part, the nurses have experience serving clientele groups of various ages, races, and socio-economic status

backgrounds (see Table 2.4). Very few nurses, however, have devoted their careers to serving the elderly. Nearly three-quarters of the respondents claimed that they had at no time worked with a predominantly old clientele. The average percentage of eligible working years delivering health care to the aged was low for nurses of both races ($\bar{x}=8.79$).

At the time of the study, 23.9 percent of the nurses were working with a predominantly old clientele. As can be seen in Table 2.5, those who worked with the aged did so in nursing homes (83.3%), public or community health centers (35%), and in hospitals (29.3%). In contrast, only 7 percent of the nurses employed in schools of nursing and 16.7 percent of office nurses were engaged in geriatric care.

Approximately one-fifth of the sample have worked with a predominantly young clientele and most have averaged around 5 percent of their career lives with this age group. Over half of those employed in industry, government, and schools claim that their clientele is young. As might be expected, just under 15 percent of those in other facilities, with the exception of nursing homes, worked mainly with the young.

Six percent of the nurses have worked with a predominantly middle-age clientele. This is not surprising, since few facilities cater to patients in their middle years. Indeed, the largest percentage of nurses (6.7%) who claimed to work with the middle-aged clientele were those who were employed by physicians.

Over one-third of the nurses have worked with clients of all ages and have spent 15 percent of their career lives doing so. Over half of those who worked in hospitals (53.7%) and in physicians' offices (63.4%) saw patients of all ages, as have 45.3 percent of those in community and public health sites.

RACE OF PATIENTS

Black nurses spent an average of four times their career lives ($\bar{x}=26.6\%$) serving members of their race than did whites

TABLE 2.4

NURSES' EXPERIENCE SERVING DIFFERENT TYPES OF CLIENTELE GROUPS
(Percentages reported unless specified)

	<u>Total</u>	<u>White</u>	<u>Black</u>
AGE OF PATIENTS*			
OLD Predominant			
Presently working with	23.9	24.2	21.9
Percent of total R.N. Years			
0	72.4	71.4	77.3
1 - 25	15.1	16.7	10.2
26 - 50	5.9	5.8	5.2
51 - 75	2.9	2.9	2.1
Over 75	1.7	2.6	2.7
Mean Percentage of R.N. Years	8.79	8.67	8.98
MIDDLE AGE Predominant			
Percent Who Have Served Middle Age	6.0	6.3	3.9
Mean Percentage of R.N. Years	1.61	1.77	1.01
YOUNG Predominant			
Percent Who Have Served Young	19.6	20.9	15.1
Mean Percentage of R.N. Years	5.15	5.36	4.98
ALL AGES			
Percent Who Have Served All Ages	35.1	38.7	21.2
Mean Percentage of R.N. Years	15.2	16.48	10.0
RACE OF PATIENTS*			
BLACK Predominant			
Presently working with	12.9	9.2	25.7
Percent of total R.N. Years			
0	79.1	83.3	47.2
1 - 25	10.1	8.0	16.9
26 - 50	4.1	3.5	11.4
51 - 75	2.8	4.0	12.2
Over 75	2.4	1.2	12.3
Mean Percentage of R.N. Years	6.98	6.12	26.58

*Categories with combination of characteristics not listed.

TABLE 2.4 CONTINUED

	<u>Total</u>	<u>White</u>	<u>Black</u>
WHITE Predominant			
Percent Who Served White Patients	42.9	45.0	34.3
Mean Percentage of R.N. Years	15.28	16.2	11.9
SPANISH and OTHER Minority Predominant			
Percent Who Served Other Minorities	9.0	5.9	17.9
Mean Percent of R.N. Years	.43	.29	.98
ALL Races			
Percent Who Have Served All Races	33.9	35.8	26.7
Mean Percent of R.N. Years	15.6	16.0	14.2
SOCIO-ECONOMIC STATUS OF PATIENTS*			
POOR Predominant			
Presently working with	27.6	21.2	49.3
Percent of total R.N. Years			
0	64.4	69.4	51.0
1 - 25	18.5	14.4	12.2
26 - 50	7.1	6.3	8.7
51 - 75	4.5	6.3	17.1
Over 75	5.5	3.6	11.0
Mean Percentage of R.N. Years	12.48	11.64	29.57
UPPER CLASS Predominant			
Percentage Who Have Served Upper Class	4.8	5.0	3.9
Mean Percentage of R.N. Years	.7	.7	.72
MIDDLE CLASS Predominant			
Percentage Who Have Served Middle Class	29.4	31.9	19.6
Mean Percentage of R.N. Years	9.77	10.82	5.65
ALL CLASSES			
Percent Who Have Served All Classes	30.9	34.2	19.7
Mean Percentage of R.N. Years	13.26	14.36	8.91

*Categories with combinations of characteristics not listed.

($\bar{x}$ =6.12%). Over 80 percent of the white respondents reported never having worked with a predominantly black clientele. Interestingly, 47.2 percent of the black nurses had not done so either. Still one-quarter of the blacks had spent the majority of their R.N. years delivering health care to black patients, whereas only 5.2 percent of the whites had been similarly occupied.

The largest percentage of nurses (28.7%) who served a predominantly black clientele were employed in community or public health. Few who worked in nursing homes (5.9%) and in doctor's offices (3.4%) claimed that the majority of their patients were black. Approximately 12 percent of those employed in schools of nursing, industry, and hospitals were serving black clients.

Black nurses also were more likely than whites to serve patients of other ethnic backgrounds. In addition, blacks spent more of their career years in minority care. Still a very small percentage of nurses in any type of health facility felt that they predominantly served members from ethnic minority backgrounds.

Over 40 percent of the respondents worked with predominantly white clients. White nurses were somewhat more inclined to be responsible for the care of white patients than were blacks, but the differences are not significant. Nurses employed by nursing homes (45.1%) and by physicians (50.9%) were most likely to see and care for white clients.

One-third of the nurses claimed that they worked with clients of all races. Whites (35.8%) were more likely to make this claim than were blacks (26.7%), and white nurses spent slightly more of their career time in multi-racial settings. Still, the largest percentage of nurses working in each type of facility claimed to be responsible for the health care of persons from all racial and ethnic backgrounds.

TABLE 2.5
PRESENT WORK PATTERN BY FACILITY
(Percentage reported unless specified)

	Hospital	Nursing Home	Public Health	HMO Doctor Office	Industry Gov't School	School of Nursing
Percent Working in:	61.7	5.8	9.8	4.8	6.0	5.0
Mean Years in:	6.04	4.35	6.98	9.23	9.07	5.30
Field of Nursing						
Medical, surgical	41.8	20.5	12.3	24.3	5.8	9.3
Geriatric, rehabilitation	2.2	63.1	4.1	0	.6	0
Pediatrics	5.8	.5	4.7	2.8	1.6	3.6
Psychiatry	5.3	3.7	6.3	1.1	.6	8.2
Obstetrics, gynecology	10.3	.9	4.5	56.4	0	4.2
Public health	.4	.9	57.8	0	3.9	2.0
Intensive, coronary care	13.2	0	.3	.6	.3	.5
Emergency	4.6	.5	.8	0	.6	0
Operating Room	6.9	.5	0	.6	0	0
Administration	5.0	6.8	2.4	0	.6	4.1
Education	1.4	.5	.3	0	1.9	58.8
Research	.2	0	.5	0	0	0
Position						
Private duty	1.8	1.7	1.3	1.6	.3	0
Staff	59.8	40.3	37.2	6.5	10.1	2.0
Head nurse	14.8	15.6	7.9	1.6	4.4	.5
Certificate specialty	2.7	.9	2.3	1.6	0	1.0
Supervisor	12.6	21.2	15.6	1.1	2.8	3.6
Teacher	1.7	1.3	1.5	0	5.1	40.6
High level administrator	4.7	15.6	8.5	2.7	.3	4.6
Location						
Rural	6.9	17.3	10.8	10.1	14.3	7.3
Town	3.3	4.9	2.6	6.7	5.3	3.1
Suburb	16.5	28.8	11.1	19.1	25.2	10.9
City	58.2	40.3	50.1	57.3	38.9	62.2
Inner city	14.2	7.1	19.8	6.2	14.0	16.1
Full-time	74.0	60.0	82.4	63.2	81.1	83.9
Part-time	22.8	37.4	15.8	34.6	17.3	14.5
Both	3.2	2.6	1.8	2.2	.6	1.6

TABLE 2.5 CONTINUED

	<u>Hospital</u>	<u>Nursing Home</u>	<u>Public Health</u>	<u>HMO Doctor Office</u>	<u>Industry Gov't School</u>	<u>School of Nursing</u>
Hours						
Day	46.7	60.1	90.3	82.7	82.8	77.8
Evening	17.8	13.5	2.1	2.4	3.7	1.2
Night	14.7	10.8	.5	0	2.0	1.2
Rotate	18.9	13.0	4.0	4.2	7.9	11.6
Distance of Facility from Home (mean)						
	7.83	7.01	8.66	6.64	8.44	10.04
Time in direct Patient Care (mean percentage)						
	64.39	50.30	55.14	75.03	64.17	23.61
Socio-Economic Status of Pts.						
Upper	1.2	5.3	.4	.9	0	1.5
Middle	24.3	16.0	7.9	45.0	18.6	11.7
Lower	26.5	41.5	57.5	6.4	20.9	16.8
All	46.4	35.1	32.7	47.7	45.8	25.5
Age of Patients						
Young	10.4	4.0	14.8	13.3	54.8	14.8
Middle Age	5.4	1.0	2.7	6.7	3.2	.9
Old	29.3	83.3	35.0	16.7	0	7.0
All	53.7	10.6	45.3	63.4	31.3	34.4
Race of Patients						
White	28.1	45.1	12.0	50.9	21.0	11.5
Black	12.4	5.9	28.7	3.4	12.9	10.8
Other minorities	1.6	2.0	4.8	1.8	3.4	1.5
All	56.7	45.1	53.1	53.9	53.8	35.8
Number of Employers						
1 - 2	45.3	18.3	23.2	24.8	20.0	11.1
3 - 4	30.1	32.9	35.9	35.4	30.1	32.4
5 or more	24.6	48.8	40.9	39.8	49.9	56.5

SOCIO-ECONOMIC STATUS OF PATIENTS

The majority of nurses had never worked with a predominantly poor clientele. A larger percentage of blacks had experience in facilities which served the poor (48.91%) than had whites (21.2%). Indeed, 28.1 percent of the black respondents claimed to have spent over half of their careers serving poor patients, as compared to only 9.9 percent of the whites. In addition, whereas blacks had worked an average of 29.57 percent of their eligible R.N. working years in such service, whites reported an average of 11.64 percent.

At the time of the survey, 27.6 percent of the nurses were working primarily with poor clients. Nearly half of the black nurses were working with lower socio-economic status clients, as compared to only 21.2 percent of the whites. Over 40 percent of those working in nursing homes, and 57.5 percent of those in public health claimed that the majority of their patients were poor. One-quarter of the hospital nurses were serving predominantly low socio-economic status patients.

Few nurses of either race claimed to have worked predominantly with upper class patients. Moreover, they averaged less than 1 percent of their R.N. years in the care of the rich. At the time of the study, 1 percent of the nurses were charged with providing health services to the upper class. The largest percentage (5.3%) of those who served the rich were employed by nursing homes.

Almost 30 percent of the nurses reported working predominantly with the middle class. Whites (31.9%) were more likely to make this claim than were blacks (19.6%). Moreover, white nurses spent twice the proportion of their career years in serving the middle class ($\bar{x}=10.82\%$) than did their black colleagues ($\bar{x}=5.65\%$). Nurses employed by physicians (45%) were most likely to see middle class patients and approximately one-quarter of the hospital nurses primarily served clients of the middle class.

Over 30 percent of the respondents stated that they served clients from all socio-economic status backgrounds. Blacks (19.7%) were much less likely to make that claim and spent a smaller proportion of their careers ($\bar{x}$ =8.91%) in caring for patients of all classes than did whites (34.2% and $\bar{x}$ =14.36%). Hospital, industrial, and physician office nurses were most likely to have patients from all socio-economic strata than were those employed by other types of facilities.

WHO WORKS IN SHORTAGE AREAS WITH UNDERSERVED CLIENTS?

The nurses' personal and educational characteristics were examined to ascertain who works with underserved clientele groups in shortage areas. Shortage areas, as mentioned above, are rural and inner city locales; and the elderly, poor, and persons of minority backgrounds constitute the medically underserved. Those characteristics which were found to be relevant are present in Table 2.6.

As mentioned earlier, very few nurses spent time working in rural areas. Looking at those persons who spent at least 15 percent of their career lives working in rural areas, it is seen that older nurses, who graduated prior to 1960, and who were reared in sparsely populated locales meet that requirement. It should be especially noted that those raised in rural areas are the most likely to return there to work for a significant proportion of their R.N. years.

More persons work in the inner city than in rural areas. Thus, we will look at the attributes of those who spent at least 20 percent of their work lives in the inner city. Unmarried nurses, who have an associate degree or have continued their education for either a baccalaureate or graduate degree, who have graduated during the past two decades, and who are between 30 and 39 years of age were the most likely to have worked in the inner city. These nurses have been raised in large cities.

TABLE 2.6
PERSONAL AND EDUCATIONAL CHARACTERISTICS
AND TIME SPENT WORKING IN SHORTAGE AREAS
(Mean percentages reported)

	<u>RURAL AREAS</u>	<u>INNER CITY AREAS</u>	<u>OLD CLIENTS</u>	<u>POOR CLIENTS</u>	<u>BLACK CLIENTS</u>
Married	14.1	17.3	17.3	19.9	15.3
Single	10.3	24.0	17.1	24.8	18.8
Parent	14.3	18.3	17.6	20.8	15.9
Non-Parent	11.2	20.8	17.0	23.0	18.3
Associate	13.1	23.8	22.8	28.3	21.4
Diploma	14.0	18.4	16.5	19.5	15.3
Bacc.	11.5	18.2	16.6	24.1	18.1
Cont. Bacc.	11.4	23.2	15.6	23.0	19.4
Grad.	10.6	22.1	12.2	24.5	18.8
Graduated Nrs. School					
before 1940	17.6	17.3	18.9	19.4	16.7
1940 - 1949	14.6	15.4	15.2	17.2	13.8
1950 - 1959	15.0	18.6	15.6	20.7	15.7
1960 - 1969	11.2	21.1	17.3	23.5	17.7
1970's	10.9	21.4	19.7	24.3	18.2
AGE					
20 - 29	10.0	16.5	16.5	19.4	15.2
30 - 39	11.5	23.6	18.4	23.8	18.0
40 - 49	14.4	19.7	16.8	23.2	17.5
50 - 59	15.8	17.1	17.8	19.8	15.4
Over 60	15.5	16.7	17.3	18.3	15.5
RAISED					
Rural	18.5	15.7	19.9	20.4	13.7
Town	15.2	16.3	17.6	19.6	15.1
Suburb	11.3	17.0	17.9	18.7	15.1
Small City	12.8	19.4	16.8	22.8	17.9
Large City	8.4	25.8	15.3	24.6	20.3
White	6.5	8.8	8.7	11.64	6.12
Black	1.9	29.21	9.0	29.57	26.58

The large percentage of black nurses who have experience working in the inner city should be particularly noted.

Several attributes stand out as characteristics of those who serve the poor. First, collegiate based nursing education seems to be a prerequisite for delivering health care to the poor. Those who have graduated after 1960 and those who were raised in large cities spent nearly 25 percent of their careers with poor patients. Black nurses constituted the one group that had spent 30 percent of their working years in the service of poor patients.

Similarly, black nurses stand out as those who spent the highest proportion of their career lives delivering health care to black patients. Black clients were also cared for by associate degree nurses who were raised in large cities.

There are few distinguishing characteristics of those who served the old. Graduates of associate degree programs during the 1970's and who have been raised in rural areas were the only nurses who showed a particular tendency to work with elderly patients.

We had asked student nurses about their work experiences both prior to and during their nursing educational program. In addition, we asked them about future work plans. While many were still not certain about future work plans, it was clear that working with the elderly was not given high priority. As can be seen in Table 2.7, almost all the students thought that they would be employed by hospitals (95.7%). In contrast, the lowest percentage of students believed that they would work in nursing homes (13.8%).

The same pattern emerges when one examines the students' clientele preferences. While over 60 percent of the students claimed that it was likely they would work with such clients as the young, poor, and minorities, only 49.4 percent thought they would serve the old. It is interesting that this lack of interest in serving the aged was not related to a lack of desire for working with chronically ill patients; 76.4 percent claimed

TABLE 2.7
WORK PLANS OF STUDENT NURSES
(Percentages reported)

	<u>Very Likely</u>	<u>Likely</u>	<u>Unlikely</u>	<u>Unlikely</u>
<u>After you graduate, how likely is it you would work in each of the follow- ing health facilities:</u>				
in hospital	77.7	18.0	2.8	1.6
in a nursing home	2.2	11.6	33.4	52.7
in a rehabilitation center	5.2	25.6	39.8	29.5
in a public or community health center	17.1	37.6	28.2	17.1
in a school of nursing	8.9	25.8	33.4	31.9
in industry of government	6.3	24.0	34.5	35.2
in home nursing	4.7	18.6	37.1	39.6
in a doctor's or dentist's office	9.8	29.7	28.7	31.8
<u>Are you planning to work with a clientele that is predominantly:</u>				
children	25.5	34.8	28.0	11.7
old	10.6	38.8	35.1	15.4
poor	16.3	58.5	21.7	3.5
affluent	6.9	56.4	30.3	6.4
black	13.3	61.1	21.7	3.9
white	18.2	74.0	6.8	.9
ethnic minorities	12.5	59.8	23.7	4.0
acutely ill	33.3	55.1	9.1	2.5
chronically ill	22.4	54.0	18.7	4.8
<u>Facilities in which those who intend to serve the elderly plan to work:</u>				
hospital		96.2	3.8	
nursing home		32.3	67.7	
rehabilitation center		44.0	56.0	
public or community health		63.8	36.2	
school of nursing		33.8	66.3	
industry or government		37.6	62.4	
home nursing		33.2	66.8	
doctor's or dentist's office		42.5	58.4	

that it was likely they would work with patients suffering from chronic diseases.

Controls were undertaken to ascertain the types of health facilities in which students desiring to work with the elderly believed that they will be employed. These students did not plan to work in settings associated with aged patients. Only one-third envisioned that they will work in nursing homes or in patients' homes. Slightly more (44%) believed that they will be employed by rehabilitation centers. Indeed those who expected to work with the old intend to do so in hospitals and public or community health centers.

Table 2.8 compares background characteristics of the students who plan to work with the old with those who do not. As can be seen, the only personal background variable which correlates with plans to work with the elderly is race. A larger proportion of minority students than whites felt that it was likely they will work with the old. In contrast to the 46.1 percent of white students who had chosen this age group client, 54.9 percent of blacks, 63.8 percent of Hispanics, 62.5 percent of American Indians, and 64.1 percent of Asians had selected to serve the elderly.

While the nursing educational program was not highly related to client age preference, it can be seen that a larger percentage of students enrolled in the associate degree program (54.4%) believed it is likely that they will work with the old. This compared to only 47 percent of the diploma and baccalaureate degree enrollees.

The one clear relationship found was that those with experience in geriatric care, regardless of whether obtained prior to or after entering nursing school, were most likely to believe they will work with the aged in the future. Over 60 percent of those who had worked in nursing homes prior to entering nursing school intend to continue serving the elderly, as compared to less than half of those who had worked in other types of facilities. This interest was also evident among students who

TABLE 2.8
SELECTED PERSONAL, EDUCATIONAL, AND WORK CHARACTERISTICS OF STUDENT
NURSES AND THEIR PLANS TO WORK WITH THE ELDERLY
(Percentages reported)

	<u>Plan To Serve Elderly</u>	<u>Do Not Plan To Serve Elderly</u>
<u>Marital Status</u>		
Single	48.7	51.3
Divorced	52.7	47.3
Married	47.6	52.4
<u>Race/Ethnic Group</u>		
White	46.1	53.9
Black	54.9	45.1
Hispanic	63.8	36.2
American Indian	62.5	37.5
Asian	64.1	35.9
<u>Nursing Educational Program</u>		
Associate	54.4	45.6
Diploma	46.6	53.4
Baccalaureate	47.6	52.4
<u>Health Facilities Worked In Prior To Nursing School</u>		
Nursing Home	60.2	39.8
Hospital	49.2	50.8
Public Health	44.4	55.6
Doctor's Office	44.9	55.1
<u>Health Facilities Worked In While Attending Nursing School</u>		
Nursing Home	55.1	44.9
Hospital	47.7	52.3
Public Health	53.8	46.2
Doctor's Office	31.3	68.3

worked in nursing homes, rehabilitation centers, and public health facilities while in school.

NURSE PRACTITIONERS AND MALDISTRIBUTION

President Carter's 1980 budget contained only one provision for nursing education -- \$13 million for nurse practitioner training programs. It is assumed that nurse practitioners, trained in primary skills, will alleviate the problems created by the maldistribution of health personnel, particularly physicians. Using the data from the questionnaire responses of the 57 nurse practitioners and 72 clinical nurse specialists in our sample, we decided to test that assumption.

The findings indicate that nurses became practitioners and clinical nurse specialists by a variety of continuing educational routes. Neither their number of years nor number of credits earned in continuing education is uniform. Over half of the practitioners and one-third of clinicians held less than a baccalaureate degree. A larger percentage of those who claimed to be clinical nurse specialists, however, held graduate degrees (34.8%) and have spent more years continuing their education (median 2.37 years) than did those stating that they are practitioners (11.5% and median 1.97 years).

An examination of the nurse practitioners' and clinicians' work patterns demonstrates that few work in facilities that encourage independent primary care. The majority of both groups worked in hospitals and schools. In addition, few primary care nurses worked in rural areas (4%), and only one-fifth worked within inner city locations.

Nurse practitioners appeared to have worked with underserved clients to a greater extent than have clinical specialists. Almost two-thirds of the practitioners claimed that the majority of their patients were poor, while one-third served predominantly minority populations. The elderly, however, were receiving attention from only 22 percent of these nurses. In contrast,

those nurse clinicians who worked in patient care capacities seemed to have served clients of all ages, races, and socioeconomic classes.

SUMMARY

This chapter examined the work patterns of registered nurses to ascertain whether or not they were working in underserved locations and with underserved populations. The findings demonstrated that nurses were not working in those facilities, fields, and locations in which they are most needed. While 20 percent of the nurses have experience working in community health, only 10 percent have worked in extended care facilities and 5 percent in institutions of higher education. Few nurses worked in geriatrics (9.9%) and intensive (15%) and emergency (8%) care. Fewer than one-quarter of the nurses have ever had experience working in rural or inner city areas.

In addition, very few nurses have devoted their career to working with elderly, poor, or minority patients. Over 70 percent of the nurses have no experience working with a predominantly old clientele and over 80 percent of white respondents had never worked in a setting where the majority of patients were black. In addition, over 70 percent of the nurses had not worked, at any time during their careers, with a predominantly poor clientele.

The findings of this chapter clearly indicate that there are three mechanisms available to correct maldistribution problems. First, there is merit for schools of nursing to selectively recruit potential nursing students. The only group of nurses clearly identified as having a propensity to work in rural areas were those who were raised in sparsely populated locales. In addition, increasing the number of black registered nurses appears to be an important way to increase health care accessibility to inner city residents and to poor and minority clients.

The second mechanism is to provide educational experiences in areas in need of increased numbers of nurses. While we did not present the evidence, it was found that those nurses who did not return to their home towns to work, usually remained in close proximity to their schools of nursing and their training facilities. In addition, we did see that those students who had work experience in health facilities which served the elderly were the only ones who anticipated that they may work with geriatric patients after graduation.

The third mechanism is to provide continuing education opportunities for nurses desiring baccalaureate and graduate degrees. While we did not find that nurse practitioners and clinicians were especially prone to work in shortage areas, we did find that nurses with advanced degrees were more likely to work in inner city areas and to provide health care to underserved populations.

It also should be noted that making nursing education available in rural areas may be imperative to solving the health delivery problems in that locale. This is especially important for baccalaureate degree education. Few hospitals are located within rural areas, so that the provision of health care to rural residents is usually supplied by public and community health centers. Yet, most of these centers require that nurses hold a bachelor's degree before they are employed. Therefore, the few nursing programs which are located in rural areas which are administered by community colleges will not supply the needed nurses unless there are provisions for continuing educational opportunities.

CHAPTER 3

INTEGRATION OF THE NURSING CORPS AND FEDERAL EFFORTS

Since the mid 1960's, nursing has emphasized the importance of increasing the number of minorities and the disadvantaged in schools of nursing. The stimulus for the concern was provided by several pieces of federal legislation. One was the Civil Rights Act, which mandated the integration of institutions of higher education. The second was the Nurse Training Act, which provided funds to encourage the recruitment and retention of disadvantaged students into schools of nursing, and provided scholarships and loans to help these students defray tuition costs.

In contrast to the federal efforts, very little encouragement was provided by the states and localities. With the demise of federal support for nursing education, it can be expected that integration efforts will also diminish in importance. That is, such efforts will discontinue unless state and local governmental officials assume the responsibility of mandating their continuance both by legal prescription and financial support.

It was seen earlier in this book that integration of the nursing corps is important (in addition to reasons of social equity) for the stability of the nurse labor force and because minorities assist in increasing the access to health services of poor, minority, and inner city residents. This chapter will attempt to demonstrate that governmental mandates and financial support are successful ways to increase the racial and economic heterogeneity of the nursing corps.

INTEGRATION OF SCHOOLS OF NURSING

REGISTERED NURSES

Registered nurse respondents were asked about the racial composition of their generic schools of nursing. They were asked to estimate the percentage of white and black students who attended their schools. Table 3.1 presents the racial breakdown of the schools that our black registered nurse sample attended, with consideration to the year that the nurses graduated.

TABLE 3.1
PROPORTION OF BLACK STUDENTS IN SCHOOLS OF NURSING:
DECADES 1940-1970
(Percentages reported)

Percent Black Enrollment	Before 1940	1940-49	1950-59	1960-69	1970-77
1-10	8.5	7.7	32.0	43.4	38.1
11-49	2.8	2.3	9.7	20.7	26.3
50-75	1.4	2.3	4.6	4.8	10.6
76-90	1.4	.8	2.3	3.4	10.3
91-100	85.9	86.9	51.4	27.6	14.8
N	71	130	175	145	331

As can be seen in the Table, integration of schools of nursing did not begin in earnest until the 1960's. Before that decade, the majority of black nurses attended predominantly black schools of nursing. In addition, it can be seen that even in the 1970's, over 25 percent of the black nurses attended schools with more than three-quarters black enrollment. Moreover, when section was controlled, it was seen that segregation was not a southern phenomenon, although southern schools

integrated later than those in other regions. While northern schools began to integrate in the 1950's, southern schools did not open their doors to blacks until the late 1960's or early 1970's. The pacific region appears to be the only section in which integration was the norm.

SAMPLE SCHOOLS

Of the 27 integrated schools of nursing in our sample, we found that only six were successful in enrolling over 15 percent and retaining over 80 percent of their black students. All of these schools utilized a variety of recruitment and retention practices and tried various methods of implementing such programs. With only one exception, these successful schools were located in the south and west. Indeed, 40 percent of the western and 50 percent of the southern schools were successful at both recruitment and retention. It is instructive to note that the federal government had been rigorous in enforcing integration of the southern schools. -In the west, however, it was the local governmental level that threatened withdrawal of financial support unless the schools adequately reflected the racial composition of the residents who lived in close proximity to their campuses.

THE NURSE TRAINING ACT AND RACIAL INTEGRATION

While it is difficult to present a flawless argument that the Nurse Training Act caused schools of nursing to integrate, it is possible to present empirical evidence to demonstrate that it is highly likely that the Act had a positive influence on integration efforts. Since the passage of the Nurse Training Act there has been an increase in the number of minority students admitted to, enrolled in, and graduated from schools of nursing. In 1962, black enrollments in schools of nursing

was 2.7 percent. In contrast, in 1978, 5.8 percent black enrollment was reported. While black admissions to baccalaureate degree programs have kept abreast with that of associate schools, the percentage of black graduates from the associate degree program is higher. For example, in 1978, 6.1 percent of associate degree graduates were black, as compared to 4.3 percent of baccalaureate degree graduates.

The Nurse Training Act also appears to have fostered racial and economic integration within nursing through its provision to financially support the establishment of new schools of nursing. There is a close parallel between the growth of the associate degree program in nursing and the Act. Prior to its passage, there were only 130 schools of nursing which offered the associate of arts degree. By 1977, the number of associate degree programs had increased almost fivefold, with 645 schools reporting that they offered the two year program.

Much of the integration success in nursing can be said to have resulted from the proliferation of the associate of arts degree program. As can be seen in Table 3.2, the associate degree students were from lower socio-economic status backgrounds and were more likely to be older, married, and parents than were students in other academic programs. Moreover, the associate degree program has offered many of its students, especially blacks who had been working in the health field as sub-professionals, an opportunity for upward career mobility.

Table 3.3 demonstrates that the associate degree program has made nursing education accessible and affordable to the disadvantaged student because it entails two academic years of study, is administered by publicly financed community colleges, is located in residential neighborhoods, and charges low tuition rates.

TABLE 3.2
NURSING EDUCATIONAL BACKGROUND AND STUDENTS' BACKGROUND BY RACE
(Percentages reported)

	ASSOCIATE		DIPLOMA		BACCALAUREATE	
	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>
	(46.3%)	(37.1%)	(79.0%)	(14.3%)	(70.2%)	(24.6%)
<u>Personal Background</u>						
Median age	27	31	22	23	22	22
Percent married at time of study	55.4	65.8	29.4	42.7	26.7	22.8
Percent parents	46.9	74.7	13.7	36.6	12.4	29.1
<u>Socio-Economic Status Background</u>						
Father's education -- mean years	12.2	10.2	13.4	11.3	13.9	10.9
Percent of fathers in professional occupations	19.3	7.7	27.7	12.0	33.3	11.2
Median family income (dollars)	14,838	11,574	14,937	10,375	16,536	11,735
<u>Prior Health Work Experience</u>						
Nurses' Aide	33.0	34.8	31.9	41.3	38.5	35.4
Practical Nurse	13.5	~~5.1~~ 37.6	~~9.2~~ 5.1	~~37.6~~ 19.0	~~19.0~~ 3.2	11.6

TABLE 3.3
REASONS FOR SELECTING A PARTICULAR SCHOOL OF NURSING
AND NURSING EDUCATIONAL PROGRAM
(Percentages reported)

	<u>Associate</u>	<u>Diploma</u>	<u>Baccalaureate</u>
Close to home	78.8	57.3	63.3
Reasonable tuition	70.6	62.8	33.9
Time to complete program	66.8	47.8	17.2
Could attend school part-time	39.0	4.4	16.3
Reputation of school	38.3	87.6	68.4
Curriculum emphasizes clinical skills	18.0	81.6	13.4
Associated with large medical center	19.8	69.4	47.9

RECRUITMENT AND RETENTION OF MINORITY STUDENTS

The Nurse Training Act since its inception has provided special project money to encourage the recruitment and retention of minority students. The funds could be used by schools or organizations to offer students remedial services or to offer faculty development programs to increase teacher sensitivity to minority concerns. Of the 27 integrated schools we visited, 15 had black enrollments of over 15 percent. In addition, nine schools of nursing reported both a 10 percent black enrollment and an 85 percent retention rate. As can be seen in Table 3.4, high black enrollment was either attributable to the school being located in a black neighborhood or Nurse Training Act Special Projects monies. In addition, all but two schools with high black retention rates participated in projects funded through the Nurse Training Act.

TABLE 3.4

NURSE TRAINING FUNDS AND RECRUITMENT AND RETENTION OF BLACK STUDENT NURSES

<u>Schools With 15 Percent Or More Black Enrollment</u>	<u>Special Project Monies</u>	<u>Located In Black Neighborhoods</u>	<u>Nothing Dis- tinguishable</u>
Associate Degree (N=8)	5	5	0
Diploma Degree (N=4)	2	2	1
Baccalaureate Degree (N=3)	3	0	0
<u>Schools With 10 Percent Or Higher Black Enrollment And 85% Black Retention</u>	<u>Special Project Monies</u>	<u>Faculty Development</u>	<u>Nothing Dis- tinguishable</u>
Associate Degree (N=5)	0	3	2
Diploma Degree (N=1)	0	1	0
Baccalaureate Degree (N=3)	2	2	0

FINANCING NURSING EDUCATION

STUDENTS

Students were asked how they financed their nursing education. As can be seen in Table 3.5, most of the students were financing their own education from personal or family funds,

TABLE 3.5
SOURCES OF FUNDING
(percentages reported)

Q: How are you
financing your
nursing edu-
cation?

	WHITE STUDENTS						BLACK STUDENTS					
	<u>Associate</u>		<u>Diploma</u>		<u>Baccalaureate</u>		<u>Associate</u>		<u>Diploma</u>		<u>Baccalaureate</u>	
	<u>Part</u>	<u>Full</u>	<u>Part</u>	<u>Full</u>	<u>Part</u>	<u>Full</u>	<u>Part</u>	<u>Full</u>	<u>Part</u>	<u>Full</u>	<u>Part</u>	<u>Full</u>
<u>Scholarships and Grants</u>												
State Government	4.2	2.3	7.5	1.7	15.4	2.3	15.1	15.3	15.5	6.1	15.0	11.5
Federal Government	7.1	3.3	13.3	3.2	11.4	2.4	18.2	16.4	21.0	12.8	28.8	12.1
School	6.6	1.6	11.6	1.6	13.0	3.4	4.7	2.5	17.3	2.3	22.6	3.7
Other	9.3	8.1	11.3	2.8	8.4	3.1	4.4	5.8	10.5	2.3	8.5	3.4
<u>Loans</u>												
State Government	3.6	0.3	6.6	1.1	4.0	0.5	5.4	2.5	7.5	1.5	10.6	3.4
Federal Government	9.8	2.1	11.0	1.6	17.5	2.0	8.1	4.1	14.3	2.3	20.4	4.9
School	3.8	0.7	4.2	7.0	5.6	0.4	4.7	2.7	20.3	7.5	16.0	3.0
Other	3.3	1.6	3.8	1.1	4.2	1.1	2.9	1.8	2.3	1.5	2.7	2.2
<u>Veterans or Armed Forces Benefits</u>	2.3	2.0	2.5	1.8	3.4	2.0	1.4	0.9	0.8	1.5	1.7	2.0
<u>Spouse, Family, or Relative</u>	20.7	30.3	24.8	23.2	27.5	28.1	11.9	9.2	15.8	10.5	32.3	9.6
<u>Paid by Employer</u>	5.7	0.7	2.7	0.5	6.2	1.1	4.5	1.4	7.5	0.8	3.2	0.7
<u>Personal Funds</u>	27.3	20.0	31.6	12.1	36.1	14.3	25.7	17.1	27.1	6.0	25.1	9.4
<u>Other</u>	2.1	0.9	3.6	1.0	3.5	0.7	1.1	2.3	5.3	1.5	4.4	2.7

from working, or from loans that they had secured. About half were paying by personal funds or by funds from their spouses or family. Whites, more so than blacks, were using these sources of funds to pay for part or all of their education. Generally, personal/family financing was the most dominant source among the baccalaureate degree students. Employers paid for a few students, but most often did so only for part of the costs. Higher proportions of whites than blacks (except for diploma schools) received some assistance from their employers.

Loans were the second highest type of source for financing education. The federal government was the most helpful in providing loans to students of all programs. In contrast, the state government was the least helpful. Blacks in the three programs received loans to a greater extent than did the whites.

About two in three of the black students, as compared to only one-third of the whites, were receiving financial grants to cover educational costs. The baccalaureate students received the highest amount of scholarship funds, the associate degree students the least. High proportions of black students in each program received scholarships. Most of the scholarships, however, only partially paid the cost of nursing education. The federal government was most generous in providing scholarships or grant funds. Interestingly, schools of nursing were almost as generous as the federal government in providing scholarships. Again, the state government was the least supportive of nursing education.

More students in the associate programs received aid earmarked for minority students than did those in the other programs; baccalaureate students were least likely to receive these funds. In addition, blacks received more of these funds than did those from other minority backgrounds.

Most funds were distributed to cover tuition and book costs. Over two-thirds of the diploma students received assistance that also could be used for room and board. A significant proportion of students claimed that they could use financial aid funds to

buy uniforms. While room and board were not especially needed by associate degree students (as most were enrolled in commuter institutions), many did receive funds that could be used for uniforms.

REGISTERED NURSES

Registered nurses also were asked to identify sources of funding for their generic and continuing education efforts. The responses of those nurses who graduated between 1965 and 1977 were identified and are presented in Table 3.6.

As can be seen in the Table, diploma degree students received the least amount of scholarship aid, while baccalaureate degree students received the most. State monies were difficult for all students to obtain, although between 10 and 17 percent of those in bachelor's programs received state aid. Federal scholarships were most available for black students, although school grants rivaled the federal government in helping blacks complete the four year degree program.

The federal government was most generous in providing loans to students of all programs; the state government was least helpful. Blacks in the three programs received loans to a greater extent than did whites. The most marked difference surfaced in the baccalaureate degree program, with over half of the black and only 22 percent of the whites receiving federal loans to meet educational expenses.

When examining the funding sources for continuing education costs, it can be seen that financial assistance for those who earned a post-generic baccalaureate degree was only really available from federal sources. The federal government provided 32.6 percent of nurses with scholarships and 14 percent with loans. Once again, state governments were doing little to assist registered nurses in continuing education efforts.

Federal assistance continued to dominate aiding those pursuing graduate work. While the state government continued to

TABLE 3.6
FINANCIAL ASSISTANCE FOR GENERIC AND POST-GENERIC NURSE EDUCATION
FOR BLACK AND WHITE REGISTERED NURSES
(Percentages reported)

<u>DEGREE & RACE</u>	<u>STATE SCHOLARSHIP</u>	<u>FEDERAL SCHOLARSHIP</u>	<u>SCHOOL SCHOLARSHIP</u>	<u>STATE LOAN</u>	<u>FEDERAL LOAN</u>	<u>SCHOOL LOAN</u>
Associate -white (N = 378)	9.2	11.4	10.6	2.6	16.7	3.5
Associate -black (N=217)	12.2	14.2	5.1	9.3	22.3	12.2
Diploma -white (N=531)	4.4	7.6	12.1	9.6	13.4	9.6
Diploma -black (N=137)	7.3	10.8	8.0	2.2	22.6	11.1
Baccalaureate -white (N=339)	17.1	12.1	15.1	8.0	24.5	5.0
Baccalaureate -black (N=76)	21.0	38.1	32.8	25.0	57.9	22.4
Post-generic B.S. -white (N = 154)	6.2	33.7	6.9	5.4	10.9	2.0
Post-generic B.S. -black (N=57)	18.1	30.9	7.3	7.5	20.0	7.3
Graduate degree -white (N=148)	9.8	67.5	5.6	3.5	5.6	.7
Graduate degree -black (N=41)	17.0	63.5	14.6	7.3	12.2	2.4

share only a small fraction of the financial responsibility, the federal government has been most generous with both black and white nurses. Over 65 percent of the nurses with graduate degrees have received federal traineeships and another 12 percent have received loans to defray tuition costs.

SUMMARY

This chapter attempted to demonstrate that integration of the nursing corps did not occur until the federal government mandated that it should and provided financial incentives to increase the numbers of minority and disadvantaged student nurses. It was seen that prior to enactment of the Civil Rights Acts during the 1960's, the majority of black nurses attended segregated schools of nursing.

When reviewing the outcomes of the Nurse Training Act, it was seen that the percentage of black student nurses, although still low, has increased since the Act passed in 1964. In addition, the Act's provision to financially support new schools of nursing seems related to the growth of the associate degree program -- the program which opened the doors to professional nursing to lower socio-economic status students with family responsibilities. The associate degree program did this by offering a shortened time frame for the study of nursing, by being located in residential neighborhoods, and by being administered by low tuition charging public community colleges.

Federal loans, grants, and scholarships have also helped minority and disadvantaged students defray nursing educational costs. In addition, federal funds have been generously granted to registered nurses to enable them to continue their education. In contrast, state governments have provided little financial support to nursing students.

As there is little doubt that the federal contribution to nursing education will decrease within the next few years and possibly be discontinued in the near future, it is imperative

that state and local public officials reassess their own concern with nursing educational programs. If they fail to do so (as this chapter should demonstrate), racial and economic integration of the nursing corps, which has only just started to occur, would come to a near halt. Earlier chapters should have demonstrated that if integration does not occur, nurse labor force participation rates may become less stable and the victims would most likely be those already disadvantaged by the present health delivery system -- the poor and minority residents within the inner city.

CHAPTER 4
THE 1985 PLAN

Whether it is called the 1985 Plan, entry into practice, or any other name, it is certain that state legislators and administrators will hear (if they have not already) that the nursing profession is seriously planning to require a baccalaureate degree for entry into professional practice. While the requirement had been approved in 1965, it was during the American Nurses' Association's biennial convention in Hawaii that the 1978 House of Delegates adopted Resolution Number 56, which specified 1985 as the year for implementation. Resolution 56 reads:

WHEREAS, ANA for the past 13 years has upheld the position that the minimum preparation for beginning professional practice at the present time should be baccalaureate degree education in nursing, and the minimum preparation for beginning the technical nursing practice at the present time should be associate degree education in nursing, therefore be it

RESOLVED, that ANA ensure that two categories of nursing practice be clearly identified and titled by 1980, and be it further

RESOLVED, that by 1985 the minimum preparation for entry into professional nursing practice is the baccalaureate degree in nursing....

This resolution, now known as the "1985 Plan," has been justified on the basis of nursing's need and desire to have independent practitioners within the health care delivery system. It is argued that in order for nursing to be recognized as a full-fledged profession, nurses of the future must be more autonomous and better educationally prepared.

During the two year period since the 1978 convention, ANA's established Task Force has held meetings throughout the country to discuss how to implement the new requirements for entry into practice. These sessions have produced many hours of testimony and a report has been prepared for presentation to the ANA's 1980 House of Delegates. At their June 1980 meeting in Houston, the ANA delegates are to consider the Task Force's suggestions and decide on methods by which the Plan can be implemented and enforced.

While the profession has not yet attempted to gain state legislative approval for the new requirements and to seek changes in the various state nurse practice laws (with the exception of the unsuccessful attempts by the New York State Nurses' Association), it can be expected that such efforts will be initiated within the next few years. At that time, state legislators will have to decide whether or not they shall legally sanction the baccalaureate degree requirement for professional nursing. The decision will be a difficult one, for there is little agreement about whether such a requirement ultimately will improve the level of nursing services. More importantly, nurses are not in agreement with the new requirement and many are vehemently opposed.

This chapter will discuss the attitudes of registered nurses toward the baccalaureate degree requirement. It will be seen that attitudes are negative. In addition, the chapter will outline the ramifications of the 1985 Plan. The effects will be shown to be non-random; that is, the disadvantaged will be most negatively affected. By examining responses to various items on the questionnaires and interview schedules, it will be shown which student and registered nurses will be affected by the new educational requirements. The findings show that nurses will be required to continue their education for advancement, but most will have difficulty returning to school. In addition, the findings will indicate whether schools of nursing have adapted to the prescriptions for two levels of nursing

practice. The data will demonstrate that changes have not been made to foster credit transfers or to offer education to registered nurses who want to earn their baccalaureate degree. Suggestions will be offered as to ways registered nurses can be assured that they can retain their professional status.

THE WORKING NURSES REACT TO THE 1985 PLAN

The 1985 Plan is perhaps the most controversial issue facing nursing today. Our study, as have others, shows that nurses resoundingly reject the professional/technical dichotomy. In response to the item, "Nurses with less than a baccalaureate degree are technical, not professional, nurses," 88.2 percent of the registered nurse and 76.5 percent of the student sample expressed their disagreement. The respondents also disagreed with the basic philosophy of the plan. Over 86 percent of the graduate and 72 percent of the students did not feel that nursing care would be improved by hiring more baccalaureate degree nurses.

The answers to these two questionnaire items, however, do not demonstrate the depth of ill feeling toward the resolution. Our office has received hundreds of letters and notes expressing the frustrations of nurses, especially those who graduated from diploma schools when that was the prevalent mode of nursing education. These nurses felt that their professional leaders have abandoned them and condemned them to low status. They cannot understand how their years of experience can be treated as if they were of no consequence. To quote one nurse, "I was educated to be a professional nurse, I graduated as a professional nurse, I have worked as a professional nurse, and now they think they can tell me that I am not a professional nurse!"

WHO WILL BE MOST AFFECTED BY THE BACCALAUREATE
DEGREE REQUIREMENT?

Obviously, the most seriously affected student and registered nurses are those who are attending and those who have graduated from diploma and associate degree programs. That is, 77 percent of the nursing corps would be demoted to technical status and 60 percent of the student nurses are being prepared (some unexpectedly) to serve in a technical nurse capacity. In addition, black nurses will be seriously affected if the 1985 Plan is implemented. Since 53 percent of post-1965 black registered nurses have graduated from and nearly 40 percent of black student nurses are attending associate degree nursing programs, the professional/technical split would pose serious career problems for the majority of black nurses.

Our findings demonstrate that the division between technical and professional nursing education will separate student nurses along socio-economic status and family responsibility lines. As was seen in the previous chapter, there is a positive and direct correlation between father's educational and occupational attainment and family income level and enrollment in the three types of generic educational programs. That is, poor students attend associate degree schools, while the affluent enroll in the baccalaureate degree programs.

It should be noted that this relationship does not hold for black students who, regardless of program, are from families of low socio-economic status. As was seen earlier, family responsibility is the determining factor of program choice for blacks. That is, black baccalaureate degree students are young, single, and childless, while black associate students are older, married, and parents.

Table 4.1 illustrates that family responsibility and spouse's socio-economic status are also predictors of the registered nurses highest educational attainment.

TABLE 4.1
FAMILY CIRCUMSTANCES OF REGISTERED NURSES
AND THEIR HIGHEST DEGREE EARNED
(Percentages reported)

	<u>Associate</u>	<u>Diploma</u>	<u>Continued Baccalaureate</u>	<u>Masters' or Above</u>
Educational Attainment of:				
Married Nurses	67.4	71.6	62.2	50.5
Childless Nurses	27.3	22.3	41.5	49.1
Spouse's Occupation:				
Unskilled	16.1	10.3	6.4	4.0
Business	3.8	11.9	11.6	7.9
Professional	30.5	37.2	50.5	63.9

Our findings also demonstrate that socio-economic status has an overwhelming influence on the student nurses' choice of a nursing educational program and school of nursing. As was seen earlier, students selected associate degree programs and schools because of financial reasons such as reasonable tuition, time to complete the program, and proximity to home. Diploma degree students were most interested in practical experience and obtaining clinical skills. In contrast, baccalaureate degree students were concerned with future career opportunities and earning capacity.

The dichotomy is especially difficult for those who have utilized technical nursing education as a route to upward mobility. As had been seen in the previous chapter, this poses especially serious problems for black students. Nearly 40 percent of the blacks attending associate degree programs and 19 percent of those attending diploma schools have worked as practical nurses, as compared to only 11.6 percent of the black

baccalaureate degree students. While white students have worked as nurses' aides, few have been employed as practical nurses.

Although students were aware of the trend toward baccalaureate degree education, most would select their same generic educational program again. As can be seen in Table 4.2, it is doubtful that students in technical educational programs realize that their education could create problems for their professional advancement. Few associate and diploma students believed that they will have difficulty finding work or that they will have limited opportunities for advancement. Moreover, three-fourths of the diploma students believed that their educational program was well regarded within the nursing profession.

Most technical students planned to continue their education. Yet the findings reported in the Table indicate that a substantial proportion did not appreciate the difficulties that they may face in attaining advanced placement in baccalaureate programs. However, diploma students were aware that they might be disadvantaged by not having earned a college degree or transferable credits.

IS THERE A DIFFERENCE IN CURRICULA AMONGST DIFFERENT NURSING PROGRAMS?

At each of the schools visited, Deans, Directors, or Chairpersons were asked to describe the curricula emphasis of their school of nursing. Key words were coded and tabulated. As can be seen in Table 4.3, there are clear differences between the terms used by spokespersons of the various programs. Baccalaureate degree programs were said to emphasize leadership and professional nursing based on holistic and wellness theories. In contrast, the associate and diploma programs were said to be preparing technical nurses who could provide generalized care to sick patients.

However, as can be seen from the Table, the clinical experiences provided students were not especially dissimilar. Indeed,

TABLE 4.2
STUDENT AWARENESS OF EDUCATIONAL TRENDS AND DIFFICULTIES

	<u>Associate</u>	<u>Diploma</u>	<u>Baccalaureate</u>
Percent who chose program because unaware of trend toward B.S. degree	12.8	14.0	8.0
Percent who would choose same program again	53.6	62.4	90.7
Percent who would select the baccalaureate degree if they were to choose a program again	40.2	31.5	90.7
Percent who believe that their educational program is highly regarded within the nursing profession	31.1	73.8	70.3
Percent who agree that "nurses with less than a baccalaureate degree are technical, not professional, nurses"	10.0	6.4	41.2
Percent who believe that they will have difficulty finding a nursing position	2.1	0.3	1.2
Percent who believe that they will have limited opportunities for advancement	12.9	18.4	3.2
Percent who believe that their program prepares them for pursuing advanced degree	61.9	35.6	71.6
<u>Disadvantages of Program:</u> (percent)			
Lack of college degree	14.7	71.3	4.0
Lack of college credits	4.1	38.6	3.0
Non-transferrable credits	21.3	50.0	10.7
Curricula differ from school to school	43.1	24.1	37.1

TABLE 4.3
CURRICULA EMPHASIS AND TRAINING EXPERIENCES PROVIDED
IN THREE EDUCATIONAL PROGRAMS
(Percentages reported)

<u>Curriculum emphasizes:</u>	<u>Associate</u>	<u>Diploma</u>	<u>Baccalaureate</u>
autonomy	20	20	10
change agent	10	0	20
generalist	10	40	30
holistic	30	20	60
independence	10	0	30
leadership	30	20	60
professional	20	0	60
segmented	0	20	0
sickness	60	60	20
wellness	20	20	40
skills	30	40	30
technical	50	60	10
theory	40	20	40
thinking	20	0	30
<u>Clinical experiences of students:</u>			
working without supervision	0	0	50
work as a charge nurse	64	50	60
psychiatric	91	100	90
community health	64	83	90
geriatric	64	83	90
emergency, ICU, CCU	64	100	100

diploma and baccalaureate students were provided with remarkably similar training experiences. Associate degree programs did not provide experiences in community health, geriatric, and emergency and acute care to the same extent as the other two programs. In contrast, working without supervision was the only experience baccalaureate degree students may have had which diploma students did not.

REGISTERED NURSES AND BACCALAUREATE DEGREE EDUCATION

The majority of registered nurses selected diploma schools of nursing because this was the predominant mode of nursing education when they attended school. Over half claimed that they selected their program because of its emphasis on practical experience. Graduates from diploma schools were almost unanimous in their belief that a major advantage of their basic nursing program was extensive clinical training. In contrast, it is interesting to note that over half of the students enrolled in associate and baccalaureate programs and over 40 percent of the graduates from those programs believed that lack of clinical experience was a major disadvantage of their nursing education. It is little wonder, then, that few registered nurses believed that an important way to improve nursing care was to hire nurses with a baccalaureate degree (see Table 4.4).

DESIRE TO CONTINUE EDUCATION

As can be seen in Table 4.5, the majority of graduates from associate and diploma degree schools claimed that if they were to choose a nursing program today, they would choose the baccalaureate degree program. Although over half of the graduates from all three programs have continued their education, the overwhelming majority planned to pursue higher education.

TABLE 4.4
DIPLOMA EDUCATION BEST FOR CLINICAL EXPERIENCE
(Percentages reported)

	<u>Associate</u>	<u>Diploma</u>	<u>Baccalaureate</u>
Percent of registered nurses with these degrees	14.9	69.8	15.1
Percent who selected their educational program because emphasis on practical experience	24.3	57.0	7.3
Percent who felt that an advantage of their basic nursing program was extensive clinical experience	23.2	89.0	33.8
Percent who believed a disadvantage of their basic nursing program was limited clinical experience	<u>Student</u> 52.8	<u>R.N.</u> 49.4	<u>Student</u> 3.3
			<u>R.N.</u> 2.5
			<u>Student</u> 53.7
			<u>R.N.</u> 42.0

TABLE 4.5
EDUCATIONAL PLANS AND DIFFICULTIES IN CONTINUING EDUCATION
(Percentages reported)

	<u>Associate</u>	<u>Diploma</u>	<u>Baccalaureate</u>
Percent who would choose the following nursing program if they were to make that choice now:			
Associate	33.1	11.2	1.0
Diploma	6.5	29.5	2.3
Baccalaureate	60.4	59.2	96.6
Percent who have continued their education	54.1	52.6	58.2
Percent who plan to continue their education	80.7	46.7	72.0
Percent who have earned a:			
Baccalaureate degree	7.2	13.5	--
Master's degree	2.5	6.5	17.8
Percent who found the following a problem in continuing their education:			
distance to school	33.2	35.5	33.3
financial	68.8	67.5	63.8
hours classes are held	70.3	68.6	58.2
flexibility of program requirements	48.4	47.5	36.1
no part-time program available	37.0	36.5	34.9
too few credits granted for basic nursing program	37.7	64.3	6.4

Therefore, it seems that baccalaureate and graduate degree school personnel must realize that there will continue to be a demand by registered nurses to enroll in their schools and that accommodations need to be made.

In addition, nursing leaders must realize that few nurses who have continued their education have earned baccalaureate or graduate degrees. As can be seen in Table 4.5, continuing education has been troublesome for a large proportion of the nurses. The major problems appeared to be the hours that classes were held and financial difficulties. Nearly half of the R.N.'s also had difficulty with the inflexibility of program requirements. Indeed, over 60 percent of the diploma graduates were bothered by the low credit allowances permitted them for their basic nursing program. One-third of the nurses were bothered by the inaccessibility of baccalaureate degree schools and the non-availability of part-time programs.

TRANSFERRING CREDITS TO A BACCALAUREATE DEGREE PROGRAM

Deans and Chairpersons of baccalaureate degree programs were asked about the number of credits that their schools awarded registered nurses, without examination, for their generic nursing program. As can be seen in Table 4.6, graduates from technical programs cannot be certain that they will be able to transfer any specified amount of credits toward a baccalaureate degree. Private and predominantly white institutions were more restrictive than public and predominantly black colleges in awarding transfer credit. While many view the associate degree program as the first step in a career ladder toward professional nursing, our findings do not indicate that this is so. Indeed, the only schools which assured transfer of 60 credits were those which had both an associate and baccalaureate degree component. In addition, California was the only state in which an orderly progression was found and this may well be the result of state legislation which mandated that transfer

TABLE 4.6
CREDIT ALLOWANCES FOR GRADUATES FROM TECHNICAL PROGRAMS
(percentages reported)

Number of credits awarded for generic, associate, or diploma degree without examination	<u>Private Colleges</u>	<u>Public Colleges</u>	<u>Predominantly White Public</u>	<u>Predominantly Black Public</u>
None	60.0(3)	33.3(5)	33.3(3)	33.3(2)
10-20	20.0(1)	26.7(4)	22.2(2)	33.3(2)
30-45	20.0(1)	13.3(2)	22.2(2)	0.0(0)
60-90	0.0(0)	26.7(4)	22.2(2)	33.3(2)

Number of credits trans-
ferrable from generic
technical degree program
toward a baccalaureate
degree

	<u>Associate</u>	<u>Diploma</u>
15	0.0(0)	16.7(2)
20-29	10.7(3)	25.0(3)
30-39	39.3(11)	33.3(4)
40-49	7.2(2)	8.3(1)
50-59	7.2(2)	0.0(0)
60-69*	28.6(8)	0.0(0)
70	7.2(2)	0.0(0)
Director, chairperson did not know	0.0(0)	16.7(2)

*Three of these eight schools had baccalaureate degree programs; two were located in California where transfers are mandated; and three were part of the New York City College System.

credits be awarded to graduates of accredited schools of nursing who desire continued education.

GAINING ACCEPTANCE TO BACCALAUREATE DEGREE PROGRAMS

Most disturbing was our finding that many colleges and universities did not have space available to educate the number of qualified registered nurses who wished to continue their education. This was especially true of predominantly white publicly financed colleges. As can be seen in Table 4.7, three-quarters of the public colleges that we visited, with the exception of predominantly black institutions, were refusing admission to more than 40 percent of the qualified R.N. applicants because of school space capacity problems. Moreover, when asked whether R.N.'s were given priority in admissions when space problems occur, Deans replied that when a choice must be made, the decision favors generic nursing students.

TABLE 4.7

PERCENT OF QUALIFIED R.N. STUDENTS WHO ARE REFUSED ADMISSION
DUE TO SCHOOL SPACE CAPABILITY PROBLEMS*
(Percentages of schools reported)

	<u>Less than 40%</u>	<u>More than 40%</u>
Private colleges (N=5)	80(4)	20(1)
Public colleges (N=16)	60(9)	40(6)
Predominantly white public colleges (N=9)	25(2)	75(6)
Predominantly black public colleges (N=7)	100(7)	0

*Information not available for all schools.

It is interesting to note that predominantly black institutions were most receptive to admitting registered nurse students. Many of these schools expressed concern that their own existence was precarious, because of the threat to eliminate black colleges in order to integrate all institutions of higher education. It seems that nursing must be extremely hesitant to close any baccalaureate school of nursing when space limitations can be expected to create major access problems for the many nurses who will seek further education as a result of the 1985 Plan.

EDUCATION AND THE ROUTE TO UPWARD MOBILITY

Nursing leaders are dismayed by the registered nurses' nonacceptance of the baccalaureate degree requirement. They cannot understand why these nurses are not comforted by the 1985 Plan's "grandfather clause" which states that nurses who graduated before 1985 will not be affected by the new educational requirement.

These leaders must realize that registered nurses are aware that the baccalaureate degree requirement will legitimize advancement being reserved for those with collegiate degrees. To some extent this has already occurred (see Table 4.8). Those nurses who have earned a baccalaureate or graduate degree were the most likely to advance within the profession. In contrast, nurses with associate degrees were the least likely to be upwardly mobile. A similar proportion of diploma degree nurses have careers marked by upward mobility and by downward trends.

It can also be seen that the nurses' generic educational degree appeared to dictate their chances for advancement. In contrast to the 18.7 percent of nurses with a generic associate and 19.8 percent with a diploma degree who have obtained advancement, 21.8 percent of those with generic baccalaureate degrees have upwardly mobile career patterns. Associate degree graduates

TABLE 4.8
EDUCATIONAL ATTAINMENT AND CAREER MOBILITY
(Percentages reported)

<u>Education</u>	<u>Downward Mobility</u>	<u>No Mobility</u>	<u>Somewhat Upward Mobility</u>	<u>Upward Mobility</u>
Associate degree	16.9	49.2	15.1	18.7
Diploma degree	18.1	46.9	15.2	19.8
Generic baccalaureate	14.0	48.7	15.6	21.8
Continuing baccalaureate	18.1	47.3	16.5	18.1
Graduate degree	16.9	37.9	22.9	22.3

were not especially downwardly mobile. However, almost half of associate R.N.'s have remained in the same status position as they held when graduating from their generic nursing educational program.

SUMMARY

This chapter outlined several ramifications of the "1985 Plan." It described who will be most affected by the baccalaureate degree requirement for professional nursing. It also identified whether schools of nursing were prepared for the registered nurses' demands for continuing education.

There is no doubt that nursing will proceed with its plans to mandate that baccalaureate degree education is necessary for admission into professional nursing practice. It is certain that efforts to mandate the baccalaureate degree requirement will be directed toward state legislative arenas within the next few years. While we do not wish to argue the merits of a collegiate education, we do hope that these findings alert legislators to the problems that they should address when considering the 1985 plan.

First, the findings indicate that there is little support among student and registered nurses for the baccalaureate degree requirement. We also saw that few respondents believed that such a requirement would result in improved patient care.

While most state nurses' associations have approved the "1985 Plan," it seems accurate to assume that the majority of nurses were not aware that such approval was being given. Indeed, recently in New Jersey, groups of registered nurses organized, attended their state nurses' association conventions and were successful in rescinding their organization's approval of the 1985 Plan. While other states have not as yet followed suit, it can be expected that such actions will be common when legislators consider whether or not to legally sanction the baccalaureate degree requirement.

Second, our findings should clearly demonstrate to public officials that the effects of the 1985 Plan will not be random. Seriously affected will be those groups who have found the associate degree program the route for upward mobility. Persons from low socio-economic backgrounds, blacks, older men and women, and persons with family responsibilities who have found the two year program affordable and accessible will now be denied entry to professional practice. And one must not forget those practical nurses who comprise almost 40 percent of the associate degree program's students. Are they to be told that their two years of continuing educational efforts have produced technical not professional status for them?

California has provided an example of what can be done to ease the situation for those persons most affected by the plan. The state has mandated that a school of nursing to be accredited must offer at a minimum an associate of arts degree and at least 60 credits that are transferable to a baccalaureate degree program. This does not mean that California has worked out the problem, for we found that many bachelor's degree nursing programs in that state, while granting associate and diploma school graduates 60 credits, require those students to earn

140-160 credits for graduation rather than the 120 credits required for generic nursing students. Still, the legislative mandate assures that some orderly progression between nursing programs is the intent of public officials.

Third, our findings show that there is and will continue to be high demand for baccalaureate degree education among registered nurses. Moreover, we have seen that schools of nursing are unprepared to offer such education to all those qualified to apply. In addition, registered nurses have problems of finding programs with accessible hours and locations at costs they can afford.

Several collegiate schools of nursing have begun to rectify this situation. For example, several California schools have closed their generic nursing program and have devoted all classroom space to returning registered nurses. New York State has instituted an external degree program by which registered nurses can earn nursing credits through examination and competency evaluations. Wayne State University recently has announced that it will hold baccalaureate level nursing courses for R.N.'s in various communities and at the facilities in which nurses work. These are only some of the new attempts being made to ease the way for the returning registered nurse student. They must be encouraged and additional means must be sought.

Fourth, we saw that advancement within nursing necessitates acquiring the baccalaureate degree, even today. Those nurses who are upwardly mobile are those who have earned a bachelor's or graduate degree. Graduates from diploma and associate degree programs who have not continued their education are most likely to have careers marked by stagnation. That is, after years of experience the nurses hold the same level post as they held in their first position after graduating from their generic nursing program.

Perhaps the most important finding is that, in the 15 year period since the American Nurses' Association adopted the position calling for two levels of nursing practice, students have

refused to recognize the technical/professional dichotomy. Each year students continue to register in diploma programs and each year the numbers choosing associate degree schools increase. Subsequently, each year a new cadre of graduates become registered nurses who vehemently reject any notion that they are not professional nurses.

At a minimum, state officials charged with overseeing nursing educational programs can insist that aspiring nurses receive counseling about the three types of nursing programs. Students must be made aware (unlike our student sample) that their opportunities for upward mobility in nursing will be determined by the educational program they select.

For the best, however, state officials can insist that within a state educational system, nursing programs be coordinated to assure a smooth transition between accredited schools by which registered nurses can progress from technical to professional degrees. There is little to recommend the current system which contains barriers for anyone wanting to progress beyond an educational decision made either when too young or too uninformed to realize the ramifications of that decision.

CHAPTER 5
REGISTERED NURSES AND COLLECTIVE ACTION

This past decade has erased the shock of seeing nurses in their white uniforms parading in front of a health facility carrying a placard indicating that they are on strike. Still, few persons find the scene comforting. For state and local governmental officials charged with the responsibility of providing for the health, welfare, and safety of their constituencies, the scene is especially disquieting. Telephones ring, conferences are called, and meetings are held throughout the day to negotiate and persuade the nurses to return to work.

Collective action has not been quickly accepted by or legitimized for registered nurses. It was not until 1968 that the American Nurses' Association rescinded their "no strike" policy and embarked on a high priority action-oriented program to organize nurses. Legislators and judges also were reluctant to see health workers organize to assert their claims in the employment sector. It was not until 1974 that the Taft-Hartley Law was amended to bring employees of non-profit hospitals under the jurisdiction of federal labor laws.

Of the more than one million employed registered nurses, less than 15 percent were represented by a bargaining agent in their place of employment in 1978. Of those represented, state nurses' associations bargained for the vast majority (i.e., approximately 105,000 nurses). National labor associations have organized from 25-30,000 nurses, and independent unions have organized about 6,000.

Interestingly, nurses are not happy about their collective action efforts. As will be seen in this chapter, the majority do not support unionization of nurses. While most believe that it is right for nurses to strike, they reserve

that right for efforts to improve patient care. Collective action, it will be seen, has won nurses higher salaries and greater satisfaction with the material aspects of their work. It has not, however, reduced other aspects of job dissatisfaction. The findings from this study clearly indicate that if persons empowered to improve the nurses' work environment would listen to nurses and make necessary changes, their energies would not have to be expended "later" to end work stoppages. Nurses are devoted to their work as health providers and surely would be willing allies with those responsible for providing health services to the citizenry.

This chapter will describe the nurses' level of support for unionization and strikes. It will identify the personal and educational backgrounds, work experiences, and career aspirations and satisfactions of nurses who favor collective action. In addition, comparisons will be made between those who are represented in the work place and those who are not to ascertain whether collective action has resulted in higher levels of job satisfaction.

SUPPORT FOR COLLECTIVE ACTION

We asked the nurses a series of questions about their support for collective action. They were asked if they thought that nurses should be represented by a union and whether nurses were represented by a recognized union or association in the health facility where they worked. The nurses who were represented were then asked by which type of organization (that is, by a nursing association, the AFL-CIO, or other union).

The nurses also were asked if they believed that it was right for nurses to strike and if they had participated in a strike for any of the following reasons: (1) for better pay and benefits, (2) to improve patient care, (3) to improve working conditions, (4) for better facilities, (5) for more staff, and (6) when administration refuses to negotiate. A strike

index was computed which summed the number of reasons for which the nurses thought that strike action was justified. The index scores range from 0 to 7. A score of 0 indicates that the nurses marked the item which read "under no circumstances do I believe that it is right for a nurse to strike." A score of 7 indicates that the nurses checked each of the above given reasons and wrote in at least one other reason.

The movement to unionize did not receive the support of the majority of nurses. Only 37.2 percent believed that nurses should be represented by a union. Over one-third of the nurses, however, worked in health facilities in which nurses were represented by an association or organization. The American Nurses' Association (ANA) was the official bargaining agent for the largest proportion of the represented nurses (22.6 percent). The AFL-CIO only bargained for 5 percent, and other unions such as governmental employees or educational organizations represented 9.2 percent of the nurses. By correlating support for unions with actual representation, it was seen that a number of nurses did not associate ANA representation with union activity.

Interestingly, a larger percentage (55.4 percent) of nurses believed that it was right for nurses to strike than supported unions. When examining the various reasons for supporting strikes, the most approval was given to improving patient care (49.3 percent) and to improving work conditions (40.6 percent). One-third lent support for increased staff and when administrators refused to negotiate. Better pay and benefits (28.1 percent) and better facilities (22.9 percent) received the least agreement.

The percentage of nurses who had actually participated in a strike was low (2.9 percent). The reasons given for their work stoppage action were evenly divided among improving pay and benefits, patient care, work conditions, staffing patterns, and recalcitrant administrators.

PERSONAL AND EDUCATIONAL CHARACTERISTICS

As can be seen in Table 5.1, black nurses were most supportive of unions and were most likely to be represented at work. In addition, it appears that the AFL-CIO had been somewhat successful in organizing black nurses. Blacks were also very strongly in favor of nurses' striking. They believed that work stoppages were justified for a wide range of reasons, whereas whites thought that strikes were right only when used to improve patient care.

Although the percentages of male and female nurses who were represented at work did not differ substantially, men were more supportive of unionization. Males were also significantly more militant than females in viewing strikes as a means to assert claims. A higher proportion of male nurses than females believed that nurses should strike when aggrieved about work situations. More than half agreed that it was right to strike for five of the six reasons given, whereas women agreed to that extent only to improve patient care. A most striking dissimilarity is seen when considering the material benefit reason. In contrast to only 28.1 percent of the female nurses who thought that it was right to strike for better pay and benefits, 53.8 percent of the men thought material benefits was a legitimate reason for strike action.

Major differences between nurses of varying age groups were detected in analyzing support for collective action. As Table 5.1 illustrates, the youngest nurses were most supportive of unionization (44.4 percent) and strikes (70.1 percent), while the oldest nurses were least supportive (32.7 percent unions, 44.2 percent strikes). Similarly, recent graduates and those with younger children were more inclined to favor unionization and strikes than were nurses who had graduated earlier and those with adult children.

Nurses from lower socio-economic status backgrounds were more represented by unions and nearly twice as likely to have

TABLE 5.1

PERSONAL AND EDUCATIONAL BACKGROUND AND SUPPORT FOR COLLECTIVE ACTION
(percentages reported unless specified)

	<u>Support Unions</u>	<u>Represented at Work</u>	<u>If represented, by whom:</u>			<u>Support Strikes</u>	<u>Mean Score Strike Index</u>	<u>Strike Participant</u>
			<u>ANA</u>	<u>AFL-CIO</u>	<u>Other</u>			
TOTAL	37.2	35.5	22.6	5.0	9.2	55.4	2.08	2.9
<u>Race</u>								
White	30.2	30.0	20.1	3.2	8.5	50.3	1.82	1.7
Black	62.6	54.8	31.8	13.3	11.4	72.3	2.94	7.1
<u>Sex</u>								
Female	37.2	35.4	22.6	5.1	9.0	55.4	2.06	2.8
Male	56.7	39.1	15.7	6.7	18.5	75.8	3.34	4.4
<u>Age</u>								
Before 1929	32.7	44.5	30.2	6.1	11.4	44.2	1.52	2.6
1930's	35.4	37.0	20.2	7.1	11.0	52.7	2.06	2.7
1940's	42.8	27.9	17.6	4.8	6.8	67.9	2.65	3.7
1950's	44.4	23.4	15.3	3.7	5.6	70.1	2.66	2.2
1960's	0.0	0.0	0.0	0.0	0.0	0.0	—	0.0
1970's	0.0	0.0	0.0	0.0	0.0	0.0	—	0.0
<u>Marital</u>								
Married	36.0	33.3	21.6	4.7	8.5	54.2	1.99	2.6
Widowed, Divorced	40.9	43.6	27.4	8.4	11.0	56.7	2.17	2.7
Single	39.1	36.0	21.4	6.8	10.4	59.7	2.36	3.6
<u>Children</u>								
No children	38.9	35.3	22.6	6.0	9.2	61.7	2.38	2.9
Children under 5	41.9	8.7	18.2	2.8	5.4	68.0	2.50	.9
Children 5-11	39.0	6.1	16.7	6.2	5.0	59.1	2.28	4.7
Junior High	52.6	1.4	20.8	5.7	10.5	59.1	2.95	4.3

TABLE 5.1 CONTINUED

	Support Unions	Represented at Work	If represented, by whom:			Support Strikes	Mean Score Strike Index	Strike Participant
			ANA	AFL-CIO	Other			
High School	42.5	3.3	23.4	6.5	8.6	54.4	2.01	1.6
Adult children	33.5	22.1	29.7	7.6	10.4	44.7	1.58	3.1
<u>Father's Occupation</u>								
Unskilled	46.2	41.1	25.8	7.8	9.7	60.2	2.33	3.1
Skilled	36.4	33.2	22.1	4.9	8.2	53.6	1.99	2.6
Professional	38.0	33.6	19.4	6.2	10.0	59.2	2.17	3.1
<u>Father's Education</u>								
8 years or less	38.1	9.4	24.8	7.0	10.1	45.6	2.07	3.8
9-11 years	36.4	35.2	22.9	4.5	9.4	44.6	2.00	2.6
12 years	36.5	33.0	22.3	4.5	8.0	45.6	2.05	2.1
13-15 years	34.4	29.9	17.7	5.5	9.6	39.5	2.29	1.5
16 years or more	38.0	29.6	17.8	4.0	8.4	41.5	2.21	3.1
<u>Spouse's Occupation</u>								
Unskilled	48.0	37.6	22.6	6.1	10.0	57.9	2.17	2.2
Skilled	36.7	37.3	24.6	5.8	9.3	52.9	1.89	2.8
Professional	34.8	32.5	20.6	4.4	9.1	54.8	2.02	3.1
<u>Spouse's Education</u>								
8 years or less	38.3	40.0	28.4	8.4	8.7	47.1	1.77	1.0
9-11 years	36.6	38.6	28.0	4.2	8.7	45.3	1.72	2.9
12 years	35.6	39.9	24.0	7.2	9.8	50.7	1.86	3.1
13-15 years	39.3	32.7	20.4	5.4	9.2	59.3	2.20	2.4
16 years or more	35.8	32.1	21.4	4.0	3.5	56.2	2.07	2.5
<u>Family Income</u>								
0-5,000	38.2	56.5	56.5	4.3	4.5	47.9	1.41	6.9
6-10,000	38.3	28.1	23.2	2.7	5.1	51.7	1.97	1.9
11-15,000	41.3	31.2	20.9	4.5	7.9	58.7	2.10	2.6

TABLE 5.1 CONTINUED

	<u>Support Unions</u>	<u>Represented at Work</u>	<u>If represented, by whom:</u>			<u>Support Strikes</u>	<u>Mean Score Strike Index</u>	<u>Strike Participant</u>
			<u>ANA</u>	<u>AFL-CIO</u>	<u>Other</u>			
16-20,000	40.7	39.4	24.4	6.7	9.5	55.7	2.15	3.2
21-25,000	38.2	31.8	18.0	5.2	10.8	58.6	2.22	1.5
26,000 +	39.3	38.0	23.0	6.0	11.2	56.6	2.14	4.3
<u>Primary Support</u>								
Spouse	33.7	31.1	20.6	3.7	7.8	52.3	1.92	2.4
Nurse	40.8	39.9	24.4	7.6	10.6	58.1	2.22	3.0
<u>Political Ideology</u>								
Conservative	29.0	33.6	23.1	5.3	7.4	44.3	1.65	2.2
Middle Road	35.8	34.9	22.0	4.9	9.6	55.3	1.98	2.5
Liberal	55.2	39.9	22.9	8.4	11.2	73.3	3.01	4.6
<u>Generic Education</u>								
Associate	51.0	36.7	20.1	8.9	8.9	67.3	2.69	4.2
Diploma	24.1	35.0	23.6	5.1	8.5	49.7	1.82	2.3
Baccalaureate	46.1	37.0	21.3	5.1	12.5	70.4	2.66	3.7
<u>Continued Education</u>								
Baccalaureate	40.2	47.0	27.1	9.5	14.2	62.4	2.33	4.4
Graduate degree	43.2	48.7	27.3	9.6	18.1	74.2	2.77	3.9
<u>Year Graduated: Generic</u>								
Before 1940	29.5	47.8	35.7	6.3	10.7	37.4	1.22	2.0
1940-1949	32.9	42.7	27.4	6.7	11.0	45.4	1.56	3.4
1950-1959	33.0	37.4	21.5	4.9	12.3	49.4	1.81	1.8
1960-1969	37.5	30.1	19.6	5.5	11.6	62.1	2.36	3.6
1970-1979	51.0	28.3	17.4	5.2	6.9	71.5	2.80	3.0

participated in work stoppage activities as their more affluent colleagues. However, as Table 5.1 shows, support for unionization and strikes did not differ substantially by current family income level. Differences were detected, though, between nurses from working class versus professional backgrounds. Support for unionization and strikes was highest among nurses whose fathers were employed in unskilled occupations.

Marital status was not found to be an important factor in support for collective action. All respondents, regardless of marital status, were supportive of unionization and strikes.

High educational attainment was directly and positively associated with support for collective action. Baccalaureate and master's degree graduates, perhaps reflecting the new emphasis of the nurse as an activist, were highly supportive of unionization and strikes. Associate degree graduates also supported the movement toward representation. The two-year graduates were especially supportive of strike action, perhaps reflecting their working class backgrounds and familiarity with union efforts.

Registered nurses claiming to be conservative in political outlook were least supportive of unionization, while liberals were most inclined to support representation. Nearly three-fourths of the liberal nurses supported work stoppages, compared to less than one-half of the conservatives.

PRESENT WORK SITUATION

Support for unions and actual representation was highest among nurses from industrialized states. While almost half of the California, Michigan, and New York nurses believed that nurses should unionize, less than one-third of those from Alabama, Louisiana, and Missouri agreed (see Table 5.2). Actual representation was highest in New York (55 %) and California (47 percent). The lowest proportions of represented nurses were working in Missouri (15.8 percent) and Alabama (27 percent).

TABLE 5.2

PRESENT WORK SITUATION AND SUPPORT FOR COLLECTIVE ACTION
(Percentages reported unless specified)

	<u>Support Unions</u>	<u>Represented at Work</u>	<u>If represented by whom:</u>			<u>Support Strikes</u>	<u>Mean Score Strike Index</u>	<u>Strike Participant</u>	<u>N</u>
<u>State</u>			<u>AFA</u>	<u>AFL-CIO</u>	<u>Other</u>				
Alabama	30.4	27.0	21.9	3.4	2.4	49.1	1.73	.6	336
California	46.9	46.8	24.0	14.5	13.9	69.0	2.74	12.9	529
Louisiana	32.4	29.5	19.0	4.4	8.7	63.2	2.27	2.1	286
Michigan	45.5	36.5	25.0	4.1	12.4	60.1	1.97	7.9	380
Missouri	30.7	15.8	14.4	1.5	2.2	52.7	1.86	1.8	656
New York	44.9	55.0	33.2	8.3	17.7	55.2	1.89	6.9	494
<u>Facility</u>									
Hospital	39.1	33.7	25.0	5.5	6.6	56.6	2.05	5.3	1791
Nursing Home	24.8	18.9	10.4	4.1	9.0	43.4	1.81	4.8	125
Industry	28.2	23.1	11.1	1.9	11.7	45.0	1.73	2.8	117
Public School	39.7	56.6	11.2	13.5	35.7	66.7	2.16	10.3	202
Public Health	49.8	54.2	28.9	11.4	14.8	71.6	2.44	13.8	267
Nursing School	32.3	37.1	26.5	7.2	15.6	70.1	2.64	7.1	98
<u>Position</u>									
Staff	44.1	32.8	21.3	6.1	7.0	61.2	2.25	5.6	1304
School Nurse	45.3	63.9	11.6	9.5	43.9	68.8	2.18	12.8	94
Private Duty	40.0	39.5	40.3	5.4	8.7	61.0	1.79	7.1	42
Head Nurse	36.9	39.7	30.8	5.0	7.8	52.9	2.01	3.7	298
Supervisor	27.9	--	--	--	--	45.0	1.60	4.3	328
High Administrator	20.5	--	--	--	--	46.5	1.18	4.2	143
Nurse Educator	41.4	45.0	29.0	7.2	18.9	76.9	3.18	7.4	94
<u>Salary</u>									
10,001-12,000	40.5	26.7	17.9	3.5	5.9	60.0	2.18	1.6	544
12,001-13,000	32.1	29.3	21.7	2.9	3.4	63.5	2.19	.6	140
13,001-15,000	43.3	36.4	23.3	8.5	9.3	60.7	2.52	4.4	459
15,001-17,000	39.6	50.7	26.9	10.4	12.2	57.2	2.26	6.1	282
Over 17,000	42.4	54.6	34.6	14.5	17.1	63.9	2.51	5.3	314

While the ANA represented the largest percentages of nurses in each of the states, the AFL-CIO and other unions had made inroads in the most industrialized ones.

The differences in support for strikes were not great for the nurses working in each of the six states, although the highest percentage of supporters were from California, Louisiana and Michigan. In addition, it can be seen that strike participants were most likely to be from the industrialized states, while few were from the South.

It is interesting to note that nurses who worked for governmental agencies were the most militant. Over two-thirds of the nurses employed in public health facilities and in schools supported strike action. Moreover, they thought that work stoppage was justifiable for many reasons. Public health and school nurses were most supportive of unionization, were most represented, and a sizeable percentage had participated in strikes. In contrast to other nurses, a larger percentage of publicly employed nurses were represented by the AFL-CIO and by other recognized unions.

Nurses in administrative positions were less supportive of unionization than were those in lower level positions. Office and industrial nurses also withheld support from organization efforts. Union support was related to favorableness toward strikes.

Nurses working full-time were more supportive of collective action than were part-timers. A larger percentage believed that nurses should unionize and strike, and more were actually represented in the workplace. Nurses working the evening shift were the most militant. Although they were the least represented, they were the most supportive of unions and strikes. Indeed, evening nurses were the most likely to have participated in a work stoppage action.

Nurses employed in facilities located within metropolitan areas were supportive of unionization and strikes. However, high levels of support were most noticeable among nurses who

were employed in the inner city and who served lower income and minority patients. The AFL-CIO and other unions had made the largest gains in recruiting members from the inner city. Yet, surprisingly, they had also made inroads in rural areas.

Nurses earning high salaries were most supportive of collective action. Indeed, while over half of the nurses who earned over \$15,000 per year were represented in the workplace, only one-quarter of those earning under \$12,000 were affiliated with a bargaining agent. Nurses with high salaries were more likely to have participated in a strike than were those with lower earnings. In addition, the AFL-CIO and other unions gained substantial membership from the high salaried nurses.

ASPIRATIONS, SATISFACTIONS, AND COLLECTIVE ACTION

Support for collective action appears to be related to the desire to upgrade the nurses' status. As can be seen in Table 5.3, nurses who supported unionization and strikes, while not especially service aspiring, were significantly more interested in material rewards, advancement, and expanded roles than were those who did not. In addition, those who felt most thwarted from achieving their goals were substantially more inclined to favor unionization than were those less frustrated.

Support for collective action was strongly related to job dissatisfaction. Supporters of unionization and strikes were less satisfied with each aspect of their work than were nonsupporters.

As can be seen, those nurses who favored unions also supported strikes as a legitimate means to redress nurse grievances. Yet, support for collective action did not mean that nurses were just interested in the material and convenience aspects of their work. It did signify, however, lower commitment to nursing, a greater propensity to leave nursing work, and a loss of idealism. Idealistic nurses apparently have not been

TABLE 5.3

CAREER ASPIRATIONS, ORIENTATIONS, SATISFACTIONS AND COLLECTIVE ACTION
(means reported)

	Does Not Support Union	Support Union	Not Represented	Represented	Represented by:			Does Not Support Strikes	Support Strikes
					ANA	AFL-C	Other		
<u>ASPIRATION</u>									
Service	9.56 ^A	9.24	9.48 ^N	9.29	9.58	8.63	8.71	9.74 ^C	8.77
Material	21.12 ^C	22.52	21.62 ^B	22.05	22.13	21.69	21.90	21.03 ^C	22.67
Advancement	12.35 ^B	13.32	12.71 ^N	13.00	12.96	13.31	12.90	12.51 ^C	13.85
Expanded Role	9.46 ^N	10.05	9.80 ^N	9.93	10.22	9.84	9.40	9.00 ^C	9.66
<u>ASPIRATIONAL DEPRIVATION</u>									
Service	10.17 ^C	10.60	10.30 ^N	10.39	10.49	10.32	10.12	10.22 ^N	10.33
Material	15.98 ^C	17.08	16.78 ^C	15.63	15.98	15.09	15.09	15.93 ^N	15.91
Advancement	9.37 ^C	10.14	9.65 ^N	9.67	12.96	9.84	9.49	9.41 ^N	9.35
Expanded Role	13.03 ^C	14.29	13.47 ^N	13.60	13.63	13.71	13.54	12.86 ^B	13.75
Commitment	13.36 ^C	12.38	13.06 ^N	12.89	13.13	12.44	12.81	13.34 ^C	12.36
Not Leave	43.64 ^A	42.39	43.49 ^N	43.19	43.58	41.90	42.53	44.0 ^C	40.23
Convenience	10.86 ^N	11.07	10.92 ^N	10.86	10.92	10.83	10.78	10.85 ^N	10.85
Strike	1.13 ^C	3.47	1.98 ^C	2.39	2.20	2.85	2.54	.08 ^C	4.48
<u>SATISFACTION</u>									
Patient	17.01 ^C	16.09	16.71 ^N	16.49	16.48	16.11	16.85	16.87 ^N	16.51
Organization	17.11 ^C	15.20	16.51 ^B	15.99	16.23	15.90	15.95	17.22 ^C	15.69
Work Milieu	17.40 ^C	16.02	16.97 ^N	16.80	16.80	16.82	16.74	17.47 ^C	15.80
Nurse Input	15.97 ^C	14.44	15.33 ^N	15.42	15.35	15.56	15.55	16.18 ^C	14.62
Status	16.85 ^C	15.59	16.43 ^N	16.17	16.26	16.15	15.95	16.97 ^C	15.90
Idealism	11.99 ^C	11.31	11.74 ^N	11.58	11.49	11.49	11.91	12.10 ^C	11.38
SALARY	13,199 ^B	14,235	12,667 ^C	14,235	13,577	15,504	14,409	12,452	13,322

T-test difference of means:

^A significant at .05 level
^B significant at .01 level
^C significant at .001 level
^N not significant

able to accept the notion that nurses belong in unions and picket lines instead of at the patients' bedside.

HAS COLLECTIVE ACTION HELPED IMPROVE THE NURSES' WORK SITUATION?

To ascertain the effects of representation, comparisons were made between the mean scores to the aspiration, satisfaction, and salary measures of those represented in the workplace and those who were not. In addition, the means of those affiliated with different types of organizations were examined to see if representation by the various associations resulted in higher levels of career satisfaction. These findings are presented in Table 5.3.

The represented nurses generally had aspirations similar to the unrepresented, although they were more material aspiring. In addition, there were not major differences in the aspirations of nurses represented by the various agents. However, those belonging to the AFL-CIO were somewhat more interested in advancement, while ANA affiliates were more concerned with service, expanded roles, and material rewards.

The nurses who were represented in the workplace did not score lower on most aspirational deprivation measures than did the unorganized. Association with bargaining agents appeared to do little to assist in attaining one's objectives, other than providing more satisfaction with material benefits. Those associated with the ANA reported higher deprivation scores than did those represented by the AFL-CIO and other unions.

Interestingly, representation did not increase the nurses' level of job satisfaction. Overall, those who were represented reported lower satisfaction scores on each measure, although most differences were not statistically significant. Disparities were not found among members of the various associations.

An examination of the mean annual salaries earned by the nurses indicates that those supporting unions and strikes

received higher wages than did the non-supporters. Moreover, those nurses who were represented in the workplace earned significantly more than those who were unorganized. AFL-CIO affiliates had been able to obtain the highest wages, while the ANA associates reported the lowest annual earnings among the represented.

Representation had little relationship to commitment to nursing and the inclination to leave nursing work. The highest scores on these measures were recorded for affiliates of the AFL-CIO. Scores on the idealism index did not vary among those represented by the different bargaining agents.

SUMMARY

This chapter reviewed the collective action movement among registered nurses. It identified the nurses' level of support for collective action. In addition, comparisons were made between those who were represented in the workplace and those who were not to see whether collective action has resulted in higher levels of job satisfaction and material rewards. Comparisons also were made of the responses by nurses represented by different organizations to ascertain whether affiliation with a particular group resulted in higher satisfaction levels.

The findings indicate that nurses do not support unionization. However, the majority believe that it is right for nurses to strike, especially if such action is taken to improve patient care. While over one-third of the nurses are represented in the workplace, few are affiliated with unions. The ANA has organized the largest group of nurses and many of these individuals do not feel that representation by their professional association is synonymous with union activity. Few of the nurses have participated in strikes.

Those nurses most supportive of collective action were male, black, young, and from working class backgrounds. They were recent graduates and highly educated. They worked in

public agencies within the inner city or metropolitan areas and served poor and minority patients. These persons were employed full-time, worked the evening shift, and earned high salaries.

Support for collective action was related to a desire to upgrade the nurses' status and aspirational deprivation. Those who favored unionization were more material, advancement, and expanded role aspiring than were nonsupporters. They also were less committed to a nursing career and more inclined to feel that they would leave nursing work.

Support for collective action was strongly related to job dissatisfaction. Representation in the workplace, however, did not result in the nurses being more satisfied with their work. In addition, representation did not foster attainment of aspirational objectives. Representation did result, however, in the nurses attaining higher salaries and being more satisfied with material rewards.

The findings strongly suggest that by organizing, nurses have obtained traditional union rewards. Collective action won them salary increases and improved benefit packages. Since these are areas in which unions and administrators have the most experience in negotiation, it is not surprising that such rewards are obtained. However, these benefits were still being denied those nurses who were not represented in the workplace.

By organizing, however, nurses have not been able to redefine their work roles or to increase their access to organizational decision-making processes. The findings suggest that these are areas in which nurses are intensely interested and will act to improve their status. Therefore, it is expected that the nurses' collective action movement will continue to grow and gain proponents. In addition, as more nurses are drawn to unionization, the number of their strikes will increase. And if persons responsible for creating favorable work environments refuse to listen to nurses and do not improve the nurses' working conditions, they can expect to increase the number of hours they must spend at the negotiating table with nurses and their bargaining agents.

CHAPTER 6

WHO SPEAKS FOR WORKING NURSES?

Throughout this book, we have discussed a variety of nursing issues that we expect public officials to consider in the near future. We have seen that these issues affect working nurses and affect the delivery of health services. Yet, we are not certain that when these discussions will arise, the voices of all those affected will be heard. We are certain, however, that nursing professional associations will expend lobbying efforts to influence the issue outcomes.

Public officials often hear the views of professional association spokespersons when deliberating about legislation to be passed or rules and regulations to be implemented. It is accepted and expected that leaders of professional associations present and provide ideas and information to public officials about issues that affect their constituencies. And, most importantly, it is generally assumed that the leaders speak for the individuals they represent.

In this chapter, we ask "Do the leaders of nursing associations speak for the working nurse?" We investigate the extent to which the leadership can claim representation of the nurse corps in our sample states. We look at membership rates in professional associations and see who and how many participate in organizational activities and decisions. In addition, we investigate how many nurses take it upon themselves to contact public officials to express concern about nursing issues.

Our findings will show that only a small proportion of nurses belong to their professional associations. It will be seen that an even smaller number participate in organizational activities and decision-making. Moreover, we will demonstrate

that those nurses who are active in their professional associations are hardly representative of the average working nurse. And our findings will show that the average nurse does not take time to communicate directly with her public officials. Since we believe that the issues we have selected to discuss are important and that resolution needs input from a variety of viewpoints to be accepted, we offer suggestions about ways to ensure that the average working nurse is heard.

THE MEMBERSHIP OF ASSOCIATIONS

There are several professional associations that registered nurses may join. The two major professional organizations are the American Nurses' Association and the National League for Nursing. The American Nurses' Association focuses on all aspects of nurse practice, and the National League for Nursing is concerned primarily with educational issues. Nurses may join (or are required to join by conditions of membership) the national organization and state or local components of each of these major associations. There are, in addition, a variety of other nursing organizations, including religious associations, sorority and honorary groups, and nursing school alumnae associations. Moreover, black nurses have formed nursing associations for members of their race.

The membership rates of nursing associations have been declining rapidly over the past three decades. The proportion of all employed registered nurses who belonged to associations has decreased from more than one-half to approximately one-fifth who now are members nationwide. Our sample of 5,172 registered nurses reflects the low percentages in national trends.

In Table 6.1 we present the membership proportions of the registered nurses in professional associations. Less than thirty percent of our sample participants belonged to either of the two major nursing professional associations (the American

TABLE 6.1
MEMBERSHIP OF REGISTERED NURSES IN
PROFESSIONAL ASSOCIATIONS
(Percentages reported)

<u>Association</u>	<u>Total</u> (N=4556)	<u>White</u> (N=3493)	<u>Black</u> (N=895)
American Nurses' Association	29.1	26.4	38.3
National League for Nursing	7.9	6.9	11.3
State Nurses' Association	26.5	25.6	29.8
State League for Nursing	5.3	5.3	5.5
Regional/Local Nurses' Association	19.0	19.7	17.1
Religious Nurses' Association	2.1	2.3	1.7
Political Nurses' Association	1.1	.9	1.7
Nursing School Association (Alumnae)	31.0	31.3	31.0
Nurses' Sorority/Honorary Association	35.0	30.0	10.6
Black Nurses' Association	2.7	.1	15.5
Other	13.3	16.3	11.1

Nurses' Association or the National League for Nursing and their state and local affiliates). Nurse membership was highest in sorority and honorary associations and in school alumnae groups. Very few nurses had joined a religious or political nurses' organization. Over 15 percent of our black sample members (and a handful of whites) had joined the Black Nurses' Association.

The figures in Table 6.1, however, are somewhat inflated by the factor of multiple memberships. It appears that nurses who do hold membership in a professional association tend to be joiners. The majority of the associational members in the sample (51.8%) did belong to more than one organization. One-quarter of the respondents were affiliated with two nursing organizations; 16.5 percent belonged to three associations; and 11 percent held membership in four or more nursing groups.

When the personal characteristics of professional association members in our sample were examined, some interesting points were seen. The average members tended to be in their late twenties to early thirties and reported gross annual family incomes ranging from \$24-28,000. While most members were married, the single registered nurses were overrepresented in professional association rosters. Nurses occupying the higher status positions in the profession were also heavily overrepresented in the association memberships lists. One-fourth of all organizational members were staff nurses (as compared to 45 percent of the sample who held staff nurse positions). In contrast, nearly two-fifths of all professional association members were either supervisors, administrators, or educators (even though only 20 percent of all registered nurses sampled held such posts).

The educational attainment of members was a prominent characteristic of the joiners. The most educated registered nurses (that is those who had a baccalaureate degree or who had continued beyond into graduate programs) were heavily overrepresented as

members in professional nursing associations. Nearly 27 percent of all association members had completed graduate education (even though only 8 percent of white and 11 percent of black nurses in our sample had earned graduate degrees). Associate degree nurses were least likely to be members of such associations.

Our sample was divided by residence in the six sample states, and the proportions are shown in Table 6.2. Membership (especially for black nurses) was highest in the northern and central states of Michigan, Missouri, and New York. It was lowest in Louisiana and California.

NURSES' ACTIVITY LEVELS IN PROFESSIONAL ASSOCIATIONS

To see the degree of activity of the members, the nurses were asked whether they regularly attended meetings and conferences and whether they have ever held a position of leadership in their association. The percentages of nurses who held office or attended associational functions is low (see Table 6.3). Less than 3 percent of the nurses reported regular meeting and conference attendance at either national, state, or local organizational functions.

As we have seen above, the educational attainment of the nurses is a factor in explaining who is active in professional associations. Although the overwhelming majority of respondents in our study held a diploma as their highest degree, only 40 percent of the activists were hospital school graduates. In contrast, while only 8.2 percent of the nurses in the sample had earned a graduate degree, more than one-third of meeting and conference attendees and office holders have completed either a master's or doctoral level education. Thus, the average nurses are not only underrepresented as members, they also are underrepresented among voices heard in associational decision-making processes.

TABLE 6.2

PROFESSIONAL ASSOCIATION MEMBERS RESIDING IN SAMPLE STATES
(percentages reported)

	STATES											
	<u>Alabama</u>		<u>California</u>		<u>Louisiana</u>		<u>Michigan</u>		<u>Missouri</u>		<u>New York</u>	
	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>	<u>White</u>	<u>Black</u>
<u>MEMBERS OF:</u>												
American Nurses' Association	19.8	10.1	9.7	9.2	12.6	5.3	17.3	16.9	27.9	20.8	12.6	37.7
National League for Nursing	21.7	8.8	11.3	8.8	7.5	12.3	27.4	14.0	17.0	17.5	15.1	38.6
State Nurses' Association	19.9	8.6	11.0	8.0	11.5	6.2	18.5	14.2	24.1	21.6	17.0	41.4
State League for Nursing	18.8	6.9	7.5	6.9	6.3	6.9	26.2	17.2	18.8	34.5	22.5	27.6
Regional/Local Nurses' Association:	16.2	7.5	11.9	14.0	11.3	1.1	20.2	15.1	23.5	26.9	6.8	35.5
Religious Nurses' Association	0.0	14.3	12.8	14.3	10.3	0.0	17.9	0.0	30.8	14.3	28.2	57.1
Political Nurses' Association	0.0	0.0	0.0	9.1	16.7	0.0	25.0	36.4	41.7	18.2	16.7	36.4
Nursing School Association (Alumnae)	7.9	7.5	9.5	9.9	8.2	3.7	22.0	13.7	26.2	18.0	26.2	47.2
Nurses' Sorority/Honorary Association	24.1	12.2	8.6	10.2	15.5	18.4	20.7	26.5	19.0	10.2	12.1	22.4
Black Nurses' Association	0.0	7.1	0.0	29.4	0.0	3.5	50.0	27.1	50.0	17.6	0.0	15.3

Table 6.3

REGISTERED NURSES' ACTIVITY LEVELS IN
PROFESSIONAL ASSOCIATIONS AND EDUCATION ATTAINED
(Percent of activists holding various degrees presented)

<u>Organization, Activity</u>	<u>TOTAL</u>	<u>Associate</u>	<u>Diploma</u>	<u>Bacca- laureate</u>	<u>Continuing B.S.</u>	<u>Graduate</u>
American Nurses' Association						
Meeting attendee	2.3	19.6	34.8	6.5	12.0	27.2
Conference attendee	2.4	2.1	38.3	3.2	19.1	37.2
Office holder	1.6	1.6	38.7	6.5	30.6	22.6
National League For Nursing						
Meeting attendee	.6	4.2	33.3	4.2	20.8	37.5
Conference attendee	1.2	0	15.9	6.8	22.7	54.5
Office holder	.7	3.4	20.7	6.9	27.6	41.4
State Nurses' Association						
Meeting attendee	2.4	11.6	46.3	5.3	20.0	16.8
Conference attendee	2.3	5.6	36.0	10.1	11.2	37.1
Office holder	2.8	.9	37.3	4.5	24.5	32.7
State League For Nursing						
Meeting attendee	1.3	0	14.3	0	28.6	57.1
Conference attendee	.9	0	25.7	14.3	8.6	51.4
Office holder	1.3	0	28.9	4.4	33.3	33.3
Local Nurses' Association						
Meeting attendee	2.5	12.5	40.6	9.4	17.7	19.8
Conference attendee	1.7	16.5	32.4	7.4	19.1	25.0
Office holder	5.7	5.5	44.7	4.6	22.8	22.4
Alumnae Associations						
Meeting attendee	2.6	10.1	54.5	3.0	16.2	16.2
Conference attendee	1.5	0	65.0	8.3	10.0	16.7
Office holder	3.3	2.4	51.2	6.5	24.4	15.4

DO REGISTERED NURSES SPEAK OUT?

Only one-third of the registered nurses had ever communicated an interest about a nursing issue to a public official (see Table 6.4). The extent of articulation did not appreciably differ by race (as less than a two percentage point spread is seen between white and black nurses who had made any effort to contact a public official). The largest proportion of active registered nurses (nearly one-half) was found in the New York sample, which is consistent with our findings that the nurses in New York generally held the highest levels of educational attainment. In contrast, California nurses, although a highly educated group, were seen to be the least active nurses in the six states of our sample. The Louisiana and Michigan nurses were more active in making contacts as individuals than were those in Missouri and Alabama.

Letter writing was the form of contact more frequently used by nurses than was visiting or calling public officials. This is unfortunate, as talking with a public official can convey a concern more clearly than any other method, because in conversation people can amplify and explain their concerns and can convey the force of their interest. However, visiting entails travel and time that may not be available to the working nurse and telephone attempts may be difficult to make to busy public officials.

State officials received the heaviest onslaught of nurses' messages (see Table 6.5). This is understandable, for the state government is most intimately concerned about issues of working and education in the health field. The national officials, whom we have seen have done much to stimulate integration in education and finance students' school expenses, were those receiving the second highest amount of contact.

Although the public officials received most of the nurses' messages through the mails, local officials (closer to the residences of the working nurses) were visited by a higher proportion

TABLE 6.4
FEW REGISTERED NURSES COMMUNICATE WITH PUBLIC OFFICIALS
(percentages reported)

	<u>RNs in Alabama</u>	<u>RNs in California</u>	<u>RNs in Louisiana</u>	<u>RNs in Michigan</u>	<u>RNs in Missouri</u>	<u>RNs in New York</u>
Q: Have you ever called, written or visited a public official con- cerning a nursing issue?						
Called	1.3	1.7	3.4	3.4	3.4	2.6
Written	18.3	18.6	24.1	19.9	22.3	29.7
Visited	4.5	3.9	4.1	4.7	2.6	3.9
Called and written	3.2	2.6	2.9	3.0	3.8	3.8
Visited and written	2.2	2.8	4.1	3.3	1.4	3.8
Called, visited and written	4.5	3.6	2.4	4.7	2.6	3.4
No, I have not done any of these	65.9	66.8	58.9	60.8	63.9	52.9

TABLE 6.5
TYPE OF CONTACT MADE BY REGISTERED NURSES WITH PUBLIC OFFICIAL
(percentages reported)

	<u>RNs in Alabama</u>	<u>RNs in California</u>	<u>RNs in Louisiana</u>	<u>RNs in Michigan</u>	<u>RNs in Missouri</u>	<u>RNs in New York</u>
Q: If you have contacted a public official, at what level of government was the official?						
National Official						
Called	0.4	0.6	0.5	0.4	0.2	0.6
Written	1.9	2.2	3.6	3.6	3.7	1.9
Visited	4.3	0.4	0.2	0.4	0.6	1.0
State Official						
Called	2.8	2.8	4.8	4.3	4.5	3.3
Written	12.8	12.1	18.9	15.0	15.1	17.9
Visited	3.6	2.5	4.5	5.0	2.3	4.5
Local Official						
Called	2.8	3.7	4.1	4.5	3.6	2.7
Written	1.5	2.8	1.0	1.7	1.8	1.9
Visited	0.2	4.8	2.9	4.2	3.4	4.4
State and Local Officials						
Called	3.2	1.5	2.9	1.4	1.6	2.9
Written	3.2	4.3	3.8	2.9	2.3	8.3
Visited	3.6	1.9	2.6	1.8	1.2	2.4
National and State or Local Officials						
Called	0.0	0.5	0.0	0.6	0.5	0.4
Written	4.7	2.7	2.2	4.7	4.5	4.2
Visited	0.2	0.3	0.5	0.7	0.5	0.3
All Levels of Officials						
Called	1.3	0.4	0.0	1.4	0.6	0.9
Written	3.4	3.6	2.6	3.6	2.7	5.4
Visited	0.4	0.5	0.5	1.3	0.4	0.6

of nurses than were those at the state and national levels of government. Black nurses tended to visit their government policy makers more than did white nurses; although whites tended to write more often.

State officials in Louisiana and New York received mail from the largest groupings of nurses; those in Michigan, Louisiana and New York had more visits from nurses; and Michigan and Missouri officials heard from the nurses on the phone more than did officials in other states. Alabama nurses tended to pay visits to national officials more frequently than did those residing in the other states; while Louisiana, Michigan and Missouri nurses tended to write to those officials more so than did their colleagues residing elsewhere. California and New York nurses were more prone to visit their officials than were others; and Louisiana and Michigan nurses were most likely to call local officials on the telephone.

SUMMARY

This chapter investigated who public officials hear from about nursing issues. It was seen that nursing professional association leaders are active communicants. However, it also was seen that the associations represent only a small proportion of nurses and certainly do not reflect the compositional characteristics of the nursing corps. In addition, it was seen that the associational leaders do not share characteristics with the average nurse, for they have earned higher educational degrees and hold higher status nursing positions.

The findings also indicate that the majority of nurses do not write, call, or visit local, state, and federal officials to voice concern about nursing issues. Correlations with the articulation of concern show again that the highly educated, high status nurse is most likely to communicate with public office holders.

Still it must be remembered that most nursing issues considered by public leaders seriously affect the careers of the average working nurse. That he or she is not heard from surely is a problem. In the next few years, it is expected that this will change. As issues discussed in the political arena, similar to those discussed in this book, have a profound affect on the nurses' work lives, more nurses should take time to assure that their voices are heard.

In the meantime, for sound public policy mandates, it is imperative that public officials be aware of the full domain of nurse opinions. To some extent, that has been the purpose of this book. However, other steps can be taken. Public debates which revolve around nursing issues should be widely publicized. Therefore, a most likely solution would be to advertise public discussions at the health facilities in which nurses work. Publicity in nursing journals or through nursing associations, we have seen, will not reach the majority of nurses. Moreover, the demands of working and raising families often serve to deter nurses from attending public meetings. Public meetings can be held throughout the states and localities in places convenient and accessible to nurses, such as in schools or hospitals.

We hope that public officials will make efforts to hear the working nurse, for she best of all understands the problems of the health delivery system from a day-to-day practical perspective. And the best public policies are those to which diverse opinions have been expressed and heard and from which mediation of conflict has been successful.

APPENDIX

RESEARCH DESIGN AND SAMPLE DESCRIPTION

In December 1976, members of the Program of Health Services Delivery, under the direction of Dr. Eleanor G. Feldbaum, began a three-year study of student and registered nurses. The project, entitled "The Nursing Profession and Black Nurses," was funded by the Division of Nursing, Bureau of Health Manpower, U.S. Department of Health, Education, and Welfare (Project No. Ro1NU00570) and was initiated to answer two questions: 1) why are there so few black nurses? and 2) is the health delivery system adversely affected by the sparsity of black nurses?

In order to answer these questions, survey instruments were constructed to examine student and registered nurses: career aspirations, perceptions of the nursing profession's opportunity structure, career mobility and work patterns, career satisfactions, and professional, organizational, and patient orientations.

RESEARCH DESIGN

Data for the national study were collected in two phases. First, during the 1977 academic year, staff members visited 29 associate, diploma, and baccalaureate schools of nursing in 13 geographically dispersed states. At the time the study was conceived, these schools were among the most successful in integrating their student bodies. Criteria utilized in selecting schools included: state accreditation, geographic and programmatic representation, a minimum of 10 percent black student nurse enrollment, and willingness of school administrators to participate in the project.

At each school, staff members distributed questionnaires for self-administration to all available students and faculty. In addition, personal interviews were conducted with deans, chairpersons, or directors, faculty, and financial aid officers to acquire information concerning admission procedures, enrollment, curriculum design, remedial activities and programs, minority recruitment and retention strategies, and financial aid availability. Our difficulty in finding schools with 10 percent black enrollment made us aware that a significant proportion of black nurses were and continue to be educated in non-integrated institutions of higher education. Thus in 1978, the project staff visited 12 predominantly black schools of nursing in a 5 state area (New York,

North Carolina, Florida, Louisiana, and Illinois). Only schools offering the associate and baccalaureate nursing degree program were studied as we were unable to locate a predominantly black diploma school. The same survey instruments and interview schedules were used in the predominantly black and the integrated schools.

The second phase of the project involved graduate nurses registered to practice in Alabama, California, Louisiana, Michigan, Missouri, and New York. The criteria used to select these six states were: 1) geographic representation; 2) registered nurses corps with at least 10 percent black composition; and 3) containment of at least one large metropolitan area with a sizeable concentration of black residents. To ensure an adequate representation of black nurses, two samples were selected for study. The first sample, a random one, was selected from complete lists of registered nurses' names and addresses obtained from the six State Boards of Nurse Examiners. The second sample, a stratified one, was selected to obtain responses from a sizeable proportion of black registered nurses. Zip code computer tapes with census information concerning the percentage of blacks residing within each code were purchased. Only those nurses residing within zip code zones with large concentrations of black residents were mailed questionnaires. This method proved quite successful, as 18.3 percent of the completed questionnaires were returned by black nurses, rather than the 3 percent black composition which would have resulted from using only random sampling.

Overall, the registered nurse response rate was 51 percent. Follow-up postcards were mailed to nonrespondents asking several personal, educational, and work background questions. Chi-square tests were undertaken to compare the characteristics of the sample with those of nonrespondents. No statistically significant differences were found, indicating that the obtained sample was representative of registered nurses in each state (with the exception of our purposively oversampling blacks).

The total data collection effort for the national study resulted in the acquisition of 3,942 student, 589 faculty and 5,172 registered nurse surveys. Stratified sampling techniques resulted in 28.7 percent of the student and 18.3 percent of the registered nurse samples being composed of black respondents.

SCHOOLS OF NURSING SAMPLE DESCRIPTION

Overall, 18 associate, 7 diploma, and 17 baccalaureate nursing institutions participated in the national study. All diploma programs visited were considered

integrated, as none were found within predominantly black schools of nursing. Twelve of the associate programs participating in the study were integrated and six were predominantly black. Of the 17 baccalaureate schools visited, 10 were integrated and seven were predominantly black.

The majority of schools sampled were public institutions (N=35) administered by either a college or university (N=23). All were accredited by their individual State Board of Nursing at the time of the survey, and most were located in either black or racially mix neighborhoods (N=24).

Integrated schools of nursing reported a median black student enrollment of 15.0 percent, with the range varying from 2-66 percent. White students comprised the largest segment of enrollees at integrated institutions ($\bar{x}$ = 82.8%; range = 25-97%), while other minorities represented 2.2 percent of the student body (range = 0-42%). The highest enrollment of black students was found in associate degree ($\bar{x}$ black enrollment = 32.2%), publicly supported ($\bar{x}$ black enrollment = 22.5%), commuter schools ($\bar{x}$ black enrollment = 30.1%). Regionally, nursing programs in the northern ($\bar{x}$ black enrollment = 32.0%) and central ($\bar{x}$ black enrollment = 25.0%) states reported the highest black enrollments. In addition, blacks were most likely to attend integrated programs which were located in black neighborhoods ($\bar{x}$ black enrollment = 36.6%) and where faculty racial composition was over 10 percent black ($\bar{x}$ black enrollment = 27.5%).

Predominantly black schools of nursing reported a median black student enrollment of 90.7 percent (range = 43-98% black). White students comprise 7.0 percent of the total student body (range = 0-37%), while other minorities constituted 2.3 percent of predominantly black school enrollments (range = 0-46%).

Attrition data provided by the schools indicate that integrated and predominantly black institutions lose approximately one-fourth of their student body before graduation. White students appear to perform better in black institutions, as only 3 percent (median) drop out, compared to the 12 percent white attrition (median) rate in integrated institutions. Black students perform better in integrated nursing programs; a median of 12 percent of blacks drop out of integrated schools before graduation, as compared to nearly 25 percent enrolled in predominantly black schools.

STUDENT NURSES

Both similarities and differences between black and white student nurses surfaced when examining personal background characteristics. Both groups

exhibited similar characteristics with regard to age ($\bar{x}$ = 23-24), sex (92%-97% female), and marital status (45% blacks married vs 36% white), although a greater proportion of white respondents were single at the time of the survey.

Major differences between the two groups of students surfaced with regard to family background and composition. The majority of white students' parents had completed high school and some college, while the majority of black students' parents had not completed high school. Spouses of both groups of students had completed some college, although whites had completed an average of three years while blacks had finished one year of post-high school education.

Black students were twice as likely as whites to be attending school while concomitantly rearing children (blacks = 48.8% vs. whites = 20.7%). Although this difference is partially explained by black students' younger ages at marriage, it is interesting to note that they still have the same proportion of preschool and elementary school aged children in the home as do white student parents.

Striking differences were apparent between the students with respect to socioeconomic status. The combined gross annual median income reported by white students (\$20,973) was substantially higher than that reported by blacks (\$13,267). Although all students relied primarily on their parents for financial support, black students (29.7%) were twice as likely to be financially self-supporting as were whites (15.9%). Equal percentages of black and white student respondents (23.9%) reported that their husbands were the primary familial supporters.

Other differences between the students were evident with regard to political outlook and prior exposure to secondary education. Though not a major difference, blacks tended to be more liberal in outlook (32.6%) than their white counterparts (24.2%). However, whites were slightly more politically active. Although the overwhelming majority of both groups of students had never called, written, or visited a public official concerning a nursing issue, a slightly greater percentage of white (19.8%) than black students (14.5%) had done so.

Most of the students sampled had attended another institution of higher education prior to entering their current nursing programs, although more white students (67.9%) than black (53.0%) had done so. The data indicate that the black students were most likely to have been enrolled in practical nursing programs. For example, the greatest percentage of white respondents (35.4%) previously had been enrolled in baccalaureate degree nursing programs, while

blacks (48.3%) were most likely to have been working towards or have earned a practical nurse degree. For many blacks, then, their second exposure to post-secondary education represented a higher career mobility track than that offered by their practical nurse schooling and/or positions.

Substantial differences between the two groups of students were apparent in examining prior work experience and choice of generic nursing program. Over half of both groups of students reported having worked in the health field before entering their current nursing program. However, blacks were most likely to have been paid for their services (black: 69.1% paid vs white: 44.3%). Blacks, who averaged about three years work experience before entering their program, were most likely to have been either nursing aides/assistants (35.7%) or practical nurses (26.9%). In contrast, whites, who averaged less than two years work experience were much less likely to have worked as practical nurses (6.1%). A significant proportion of whites, however, had held nursing aide positions (35.7%) or reported working as volunteers (28.2%).

Overall, the highest percentages of blacks sampled were enrolled in associate degree nursing programs (45.1%); 13 percent were attending diploma and 42 percent were enrolled in baccalaureate institutions. Whites, in our samples, on the other hand, were most likely to be enrolled in baccalaureate degree schools of nursing (48.2%). Nearly 30 percent were attending diploma institutions at the time of the survey, while only 23 percent were matriculated in associate programs.

The affinity of blacks to attend associate degree programs may have been related to school proximity. Distance from home to school appeared to be of more importance to blacks than whites. Black students travelled a median distance of 10 miles to school, while whites' homes were approximately 15 miles from their schools of nursing.

FACULTY

The overwhelming majority of the nurse educators in our sample were female (98.7%) and Christian (89.5%). The average age of the faculty members was 38.7 years. Blacks composed 13 percent of the faculty sample. Over two-thirds of the teachers were or had been married and nearly half were parents. Sixty percent of the parents had preschool or elementary school age children while one-quarter were parents of adult children.

The faculty was from working class backgrounds; their father's average edu-

cational attainment was 12 years. Interestingly, over 40 percent were raised by working mothers. Black mothers were more likely to have been employed (62.5%) than were white mothers (41.5%). The faculty members were married to college educated spouses, the majority of whom were employed in professional occupations.

Half of the teachers began their nursing education in associate or diploma degree schools. Nearly all (96.3%) had earned a baccalaureate degree. Three-quarters of the faculty sample had continued their education and had attained a masters' degree. Only 6 percent, however, had earned a doctorate degree, although over 30 percent were enrolled in a doctoral level program at the time of the survey. The average teacher had waited four years after graduating with a baccalaureate degree before commencing the master's program. Doctoral work, in contrast, began almost immediately after receipt of the master's degree.

Half of the faculty members reported never having interrupted their careers. Indeed, nearly two-thirds of the teachers remained working while attending school for their baccalaureate and master's degrees. In contrast, only one-third remained employed while pursuing their doctorate degree.

Nearly all the teachers (94.2%) held full-time positions at the time of the survey. Their average monthly gross salary was reported as \$1200. They were responsible for teaching an average of 1.3 courses and 33.3 students. Nearly half of the white and 62.3 percent of the black educators held an instructor level position. Almost one-quarter held the rank of assistant professor. In contrast, few had reached tenured level positions, with 12.7 percent of the whites and 6.9 percent of the blacks being associate professors. Few (3.2% white and 1.7% black) had been promoted to full professor. Over 60 percent of the faculty had been in their present positions for less than two years.

REGISTERED NURSES

The registered nurse sample was overwhelmingly comprised of female (97.9%) and Christian (95.1%) respondents. They ranged in age from twenty-one to eighty-three, with forty-three representing the median age. Over 76 percent of the nurses were or had been married, although blacks (56.4% married) and whites (70.0% married) differed markedly in marital status. More than twice as many black (18.6%) than white respondents (7.6%) were divorced. Equal per-

centages (70%) of both black and white RN's surveyed had children. Slightly less than one-third of all nurses had children of elementary school age or younger; slightly more than one-third reported having adult children (18 years or older).

While white nurses grew up in a variety of areas (rural = 26.6%, town = 21.5%; city = 34.8%), the majority of blacks were reared in cities (65.4%). The overall combined annual family income of the nurses was quite similar. Whites reported yearly family incomes of \$20,486, while black families earned \$20,381 annually. However, the majority of whites (56.3%) reported that their spouses were the primary familial supporters; most of black nurses sampled were self-supportive (51.6%).

Perhaps reflecting the preponderance of diploma programs in the 1960's, nearly 70 percent of the nurses were educated in three-year hospital schools (72.3% of whites vs 61.7% of blacks). Black nurses were twice as likely as whites to have received their generic education in two-year associate degree programs (25.7% vs 12.0% respectively), while slightly more white (15.7%) than black respondents (12.6%) were educated in four-year collegiate programs.

Many of the nurses (62.8%) had obtained additional education since completing their generic nursing program. More black (73.3%) than white nurses (59.9%) had returned to school and had achieved a slightly higher educational level. At the time of the survey, 14 percent of black nurses had continued their education and had earned a baccalaureate and were continuing work on their Master's, while 11 percent had earned a Master's degree or above (i.e., either Ph.D. or Master's plus additional graduate credits); the corresponding percentages for whites were 13 and 8 respectively. Of those who had not returned to school, 76.2 percent of the blacks were planning to do so in the future, as compared to 52.3 percent of the whites.

At the time of the survey, 71.2 percent of the nurses were employed. Of those working, 76.1 percent were full-time and 23.9 percent were part-time employees. Over 60 percent were working in hospitals, 9.8 percent in public health, and 12.5 percent in schools, industry or physicians' offices. Nearly one-half held staff positions (44.8%) and served medical and surgical (42.6%) patients. Nearly 30 percent of the RN's worked in supervisory or administrative posts.

From a political standpoint, the two racial groups of nurses differed markedly in outlook. Nearly three times as many black (36.2%) than white

nurses (14.3%) considered themselves liberal on political issues. The majority of white RN's (55.2%) reported having a neutral political viewpoint, while black nurses were more evenly distributed along the political spectrum. However, the majority of both groups were not politically active. Nearly two-thirds of both black and white RN's had never called, written, or visited a public official concerning a nursing issue. Of those who were active, most reported having utilized written correspondence to express their viewpoints.

Overall, the national survey of nurses was very well received by students, faculty, and registered nurses. Many participants welcomed the opportunity to express their viewpoints, and judging from the thousands of requests for results, the study appears to be both timely and of keen interest to nurses across the country.

SCALE CONSTRUCTION AND WORK PATTERN DATA

Five sets of scales have been identified from the registered and student nurse survey responses: 1) career goals or aspirations; 2) career aspirational deprivations; 3) career orientations; 4) career satisfactions; and 5) sexual and racial discrimination. The scales were identified and tested for reliability and validity utilizing the following statistical procedures: factor analysis, Guttman scalogram analysis, cross validation, Kuder-Richardson tests, split-half correlational analysis, and analysis of variance. The scales were operationalized by standardizing each item and weighting the response by multiplying the standardized score by the scale-item correlation or the factor score. Each standardized and weighted scale item was then summed to produce total scale scores. The advantages of this operationalization procedure are that the scale scores are normalized and they reflect the contribution that each item made to the scale. In addition, this procedure produces scales with a large number and wide range of unique scores which aid in approximating interval level data. The scales and the items which compose each are presented in the text as the discussion warrants.

Career Aspirations - Five scales are used to measure the nurses' career objectives or motivations. These are: 1) material - the desire for extrinsic rewards, such as being granted good salaries and fringe benefits, requested hours and fields, parking, and being able to work close to home; 2) service - the desire to fulfill the traditional image of the bedside nurse devoted to patient care and comfort; 3) advancement - the desire to be promoted to more responsible positions; 4) expanded roles - the desire to perform duties usually

thought outside the realm of nursing such as teaching, research, and publishing, and to enlarge the scope of nurses' functions and influence in health care decisions; 5) continuing education - the desire to seek work in an organization which provides opportunities to further one's education and offers tuition rebates for advanced training.

Aspirational Deprivation - For each of the above measures there is a scale comprised of items which indicates whether the nurses' believe that they are being denied the opportunity for material, advancement, service, expanded role, and continuing education rewards and opportunities.

Career Orientations - Six scales pertain to career orientations. Three of these deals with patients: 1) patient orientation - the extent to which the nurse identifies and empathizes with the needs of patients; 2) patient voice - the belief that patients should have a say in their health care decisions; 3) racial tolerance - the extent to which nurses racially stereotype patients or would rather interact with those of their own race. Organizational orientation pertains to the nurses' ascription to the norms of rule and regulation following. Two scales pertain to professional orientation 1) professional orientation - the extent to which the nurses' agree with the nursing leaders that there is a need for theory-based, collegiate education and peer review; and 2) professional activism - the belief that a good nurse should be active in nursing's professional associations.

Career Satisfaction - Six scales measure various aspects of career and job satisfaction. 1) Organizational satisfaction - the extent to which nurses are happy with their employing agency and its administrative staff; 2) interpersonal relationships - the extent to which the nurses are happy with their relationships with fellow workers; 3) resource adequacy - the nurses' satisfaction with the level of resources provided them to perform tasks; 4) patient satisfaction - the extent to which the nurses are satisfied from their encounters with patients; 5) nurse input - the degree of satisfaction nurses display with their health care decisional input; 6) status - the extent to which nurses are satisfied with the level of status afforded them and other members of their profession.

Three additional measures deal with the ramifications of dissatisfaction or satisfaction. The first is commitment to nursing which looks at how happy the nurses are with their career choice and if they would select a nursing career again. The second examines the propensity to leave work (for a variety of reasons) either on a temporary or permanent basis. And the third, measures the extent to which the nurse has been able to retain a sense of idealism.

Two scales look at sexual and three at racial discrimination. A set of questions ask whether the nurses believe that males and blacks are favored in the nursing educational and work arenas; another set asks whether men and blacks are discriminated against in these settings. Another scale measures the extent to which black nurses believe that they work within a supportive environment or one marked by conflictual interpersonal relationships.

Work Patterns - The nurses' work patterns can be looked at in a variety of ways. Because the questionnaires elicited information about each job (and the month and year each job began and ended) since the nurses graduated from their generic educational program until 1977, it is possible to calculate the proportion of their eligible R.N. years they have worked: as nurses; full or part-time; in different geographic settings (e.g., rural, inner city, county, or Health Service Agency area); with different types of clients (e.g., poor, minority, old); in various types of health facilities; in different types of fields; and in different status positions. In addition, the proportion of time they have interrupted their careers, have attained various salary levels and the number of times they have changed jobs for different reasons can be ascertained.

The proportion of their career lives spent in each of the above is calculated by the simple formula:

$$\frac{\text{number of months spent in various settings, etc.}}{\text{number of months since graduation from generic nursing program}}$$

In addition, the nurses' career can be examined by various lifestages, the six that have been utilized previously are: 1) single without children; 2) married without children; 3) parents of children under six years of age; 4) parents of children ages 6 through 11 years; 5) parents of children ages 12 through 17 years; and 6) parents of children ages 18 or older.

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